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Patient-centered Medical Home
SETMA's COGNOX Project
By James L. Holly, MD
Your Life Your Health
The Examiner
October 29, 2009

The Your Life Your Health articles for February 19 to May 21st of this year examined the concept of a Patient-Centered Medical Home including what it expects of a medical practice and what it provides to patients. Those articles can be found on SETMA's website www.jameslhollymd.com under the heading of your Life Your Health, by clicking on the icon entitled "Medical Home."

Perhaps the most important aspect of being recognized as a Patient-Centered Medical Home is the ability to examine patient-care data in order:

- to change provider and patient behavior,
- to change procedures and processes in the practice and
- to provide patients with information about, and strategies for improving or preserving their health.

The organization and analysis of raw data obtained in the care of patients can produce information on the basis of which decisions, treatment plans, and plans of care can be provided to patients. These materials can help patients take charge of their own care and become actively involved in the management of their own health. In the coming three weeks, we will look at this process for three major conditions which are treated in SETMA's Patient-Centered Medical Home: Diabetes, Hypertension and Lipid Abnormalities.

The analysis of patient-encounter data may seem simple until is realized that SETMA's patients' electronic data base is huge and that it could take 36-hours to run the reports required for the above project. When it is realized that SETMA wishes to produce those reports daily, the potential problem is realized. If you want to report on something every 24 hours but it takes 36 hours to produce the reports, you can see that it is an impossible task.

COGNOS Project, Why?

This is one of the principle reasons for the COGNOS Project. By the time this article is published SETMA will be completing the fourth week of this project and expects to complete the project in seven more weeks. Here are some facts about the project.

COGNOS is an IBM computer program described as being for "Business Intelligence and Financial Performance Management." It is a data-mining software program which is elaborate, robust, complex and excellent. The use of COGNOS in healthcare is not new but it is not common place. In response to SETMA's desire and need to have real-time reporting capacity for quality measurement, and practice and provider performance, our Chief Information Officer, Richmond Holly, chose COGNOS. After one false start with another company, he chose LPS (www.lpa.com] to consult and collaborate with SETMA on this project. While SETMA's entire

IT team is involved in this project, Jon Owens is SETMA's principal liaison with LPA and the leader of this project for SETMA.

Changing Provider Behavior with Real-time Performance Reporting

There are multiple motivations for this project. The first is to change provider and patient behavior. Typically healthcare providers only receive delayed, retrospective reviews of their performance, which does not change behavior significantly, in our judgment. In the Old Testament, there is a verse which says that "because punishment against an evil deed is delayed, the hearts of men are set upon doing evil." The principle is that without immediacy between the consequences and/or evaluation of an action and the action itself, the potential for the consequence to effect positive change is diminished or eliminated. While auditing provider performance is never for punitive reasons, the principle is the same. If the reporting of the results is significantly removed in time from the events being audited, it will have little impact upon provider behavior.

In his book, *The Fifth Discipline*, Peter Senge of MIT used the classic metaphor of the Frog in Boiling Water to address the same issue from a different perspective. He explains, "If you put a frog into cool water; he will swim around. If you begin to heat that water, the change is so gradual that the frog will not recognize the danger until it is too late for the frog to escape." The same is true of patients and healthcare providers. Because the changes in patient health are generally very slow and without immediate consequences (symptoms), both provider and patient can become complacent.

The medical literature addresses this complacency with the concept of "treatment inertia," the tendency on the part of healthcare providers to do nothing, even when something should have been done. Most of the research on "treatment inertia" has been done in the medical education arena where it is expected that "best practices" will always be present. There is no intent in this project of punishment, or of boiling anyone in hot water, but the intent is to find a way to change provider behavior and to overcome "treatment inertia." SETMA believes, as is also addressed by Senge, that the only effect way to change patient and provider conduct in the face of chronic conditions which cause no short-term discomfort but which have long-term devastating consequences, is to create discomfort in both in order to overcome "treatment inertia" and/or current apathy toward inevitable bad outcomes.

Aggregated-Provider-Performance Data for the Practice

Thus, we come to SETMA's COGNOS project. Through our electronic patient record (EMR), SETMA tracks multiple quality-measures sets from numerous sources such as HEDIS, NQF, PQRI, Physician Consortium and NCQA. These measures sets are available in SETMA's EMR in a "real time" format for providers to be able to review at the time of a patient encounter. Thus, each provider can review his/her own performance on each of these measures in the examination room. This ability has already resulted in improvement in provider performance.

However, we believe there is additional benefit to be gained from aggregated-provider-performance data which compares all providers in SETMA to other SETMA providers and

comparing both against national standards of care. And, we believe that the reporting of that comparison immediately will provide great benefit to our patients. SETMA intends to begin reporting in January the results of our care of diabetes, hypertension and lipid management, as well as over 100 additional elements of quality measures related to preventive health, chronic health problems and risk stratification. We will report this on our website so that patients can not only see how they are doing – from the reports we give them during their clinic visits – but how all of our patients as a group are doing. In healthcare policy this is called "population management" and addresses the structure and processes of healthcare delivery which increases the probability of consistent and predicable quality care and outcomes in healthcare.

It is SETMA's opinion that when providers received information from hospitals, health plans or other sources about their performance from a year or more ago, that they review it and immediately forget it. Even when the data shows that their performance is substandard, its remoteness diminishes its impact. In addition, "benchmarks" – telling providers how their performance compares with an amorphous, unknown group does not have the impact as will the displaying of their performance along side their own colleagues, and particularly when it is done by name. SETMA also believes that the creation of a true and dynamic team will be encouraged by the public reporting of that performance data without the providers' names.

Unusual Requirements of NCQA Patient-Centered Medical Home

Many of the requirements for recognition by NCQA as a Patient-Centered Medical Home are procedures and/or processes which are a traditional part of the clinical practice of medicine. Some are not. It is these latter functions which are most challenging and for which our COGNOS project will be most helpful. Via the COGNOS function, it is SETMA's intent to report to all providers:

A. The day before a patient is to be seen – A report will be sent to each provider of what the patient needs during their visit the next day. This will include a list of what the patient needs in order for the patient's care to meet all quality measures which SETMA is tracking. This report will facilitate the ease of a provider and a provider's support staff making certain that every patient receives every element of care which they need and deserve. We expect to be able to do this by January, 2010.
B. The morning after the patient is seen -- The result of the providers' performances the previous day will be reported without the identity of the patient and that provider's performance will be measured against all SETMA providers. We expect to be able to do this by January, 2010. We believe that the immediacy of the report – less than 24 hours after the events – and the comparing of providers with one another will create the discomfort needed to effect change in providers' performance.
C. Monthly, without patient identification information or provider identification SETMA wide performance will be reported on our website www.jameslhollymd.com --SETMA believes that this will enable our patients to be confident that they are receiving excellent care from SETMA and it will be further motivation for our providers to raise the standard of SETMA's care. We expect to be able to start posting these results by February, 2010.

D. Quarterly SETMA will report de-identified (all patient identification removed) results to agencies to whom SETMA is accountable for quality measures -- As will be seen below, this is an NCQA requirement

A "Data Mart"

The second motivation for SETMA's COGNOS Project is that the aggregation of and the reporting on the amount of data tracked by SETMA is a major, daily undertaking and would be time and personnel intensive if it were not automated. Additionally, the size of the reports which SETMA envisions and the database from which these reports are being mined are such that without a data-mining tool, it could take longer than 24 hours to run the reports. In addition, the running of the reports could slow our system to the point that the usefulness of the EMR in patient encounters could be adversely affected. Through COGNOS, we are creating a "data mart" which will eliminate this problem. Simply put, a "data mart" is a repository for the data points required for the completion of the above described tracking. While SETMA's EMR has hundreds of thousands if not millions of data points, only about 200 are needed to evaluate he outcomes of our care. The "data mart" will create a secure folder for these data points and all queries will be pulled from the "data mart." These reports will take seconds rather than hours.

NCQA Recognition as a Patient-Centered Medical Home

The third motivation for SETMA's COGNOS Project is that SETMA is preparing to apply for NCQA (National Committee for Quality Assurance) recognition as a Patient-Centered Medical Home. NCQA has published 9 Standards with 30 Elements and 189 Data Points for recognition as a Patient-Centered Medical Home. If you meet 25% of these Data-Points you will be a Tier I; if you meet 50%, you will be a Tier II and if you meet 75%, you will be a Tier III. SETMA's goal is to be a Tier III medical home and it is also our goal to meet all 189 Data Points.

Some of the 189 Data Points are reflective of actions which have traditionally been a part of medical practice and are easily met. Others are part of the electronic patient record and are easily met by any medical practice using a robust EMR. Others however, are not things which have traditionally been done. They are challenging and require significant changes to procedures and processes in a well-run medical practice. SETMA's COGNOS Project is intended to help us meet those unique new standards of care. Some of them are:

A. Pre-visit planning – Evaluating the patient's needs before they are seen and making certain everything is available in order to meet those needs. This is a complex problem in a multi-specialty group but the COGNOS functions will make this simple.
B. Post-visit review – Follow-up of patients has always been a part of patient care but the following up of every patient to see that they obtained their medications, followed through with their referrals, etc., is complex. COGNOS will make it possible for us to do this.
C. Reporting Performance on 10 National Quality Forum (NQA) endorsed quality measures -- SETMA has chosen to report on 32 NQA measures for 2009 and is adding another 20 NQA measures for 2010. We will report our performance on these to several external

organizations as well as to the public. Of course, all patient identification information will be eliminated.

D. A written plan-of-care and treatment-plan which is personalized for each patient -- Due to SETMA's EMR, SETMA's disease management tools and SETMA's reports, we are already accomplishing this for diabetes, hypertension and the treatment of cholesterol and triglycerides. This was one of the most daunting of tasks but with the motivation of NCQA's requirements, SETMA has done it and found it to be an extremely valuable tool for our patients.
E. Calling Patients After a Visit – This NCQA requirement puzzled us for a while. The value was obvious but how to do it. In order to call ALL Patients seen at SETMA each day, it would require at least 8 full-time RNs, at a cost of over $600,000 a year. In addition, some patients would not benefit from such a call. Thus, SETMA has established a policy of calling all patients discharged from the hospital and/or emergency room and of calling clinic-visit patients whom the provider indicates would benefit from a call with the provider dictating when the call would be made and why the call would be made. Since we began this program over a month ago, this has already begun yielding benefit to our patients and providers.
F. Non-provider involvement in the patient's care – As aspects of health care become more and more precise, it is possible for someone without a medical degree to perform that function effectively and accurately. One of those areas is preventive healthcare. It does not take a physician or nurse practitioner to determine if a patient has or has not had a flu shot, is or is not allergic to eggs and to initiate the giving of a flu shot. The improving of the quality of care will be partially achieved by the involvement of many different people, at many different levels of care in the patient's healthcare experience. SETMA's COGNOS Project's pre-visit planning will allow nurses, within the scope of their licenses and skills, to perform unsupervised points of care.
G. There are many others elements of NCQA standards which our COGNOS Project will facilitate achieving; these lustrate the point.

COGNOS will allow SETMA to continue to move healthcare delivery forward and to improve the care all of our patients receive. Welcome to the future of medicine; welcome to SETMA.

Reporting of Health Care Provider Performance
By James L. Holly, MD
Your Life Your Health
The Examiner
January 28, 2010

Public Reporting of Physician and Hospital delivery-of-care performance has been under discussion for over a decade and attempts to design and deploy such have been underway for the past 4-5 years. Two programs which have met with some success are in California which is reporting on hospital performance and in Massachusetts which is reporting on Primary Care Group performance.

The medical literature contains extensive discussions on the reliability and validity of current reporting. Physicians and hospitals are obviously concerned with the metrics which are being reported. Other studies are concerned that reported data be in a format which is comprehensible to patients. Still others have studied the determinants for who uses the published performance results and what the best way of promoting its use is. One study showed that two elements added to the successful use of the data. One was the promoting of its use by e-mail. This seems intuitive as it means that the recipients are computer literate and computer users. The other element showed that retired people used the publicly reported data more often, which simply relates to available time and probably to the need for more medical services.

Voluntary Reporting by Healthcare Providers

What appears to be missing in the medical literature concerning quality reporting is public reporting voluntarily initiated by provider groups. It is in this regard that SETMA has begun reporting quality results on our provider performance. In doing this, SETMA has engaged in conversations with several national organizations which both represent physicians and/or which endorse quality measures. And, it has been in regard to the requirements of the National Committee for Quality Assurance (NCQA) for recognition as a Patient-Centered Medical Home that SETMA expanded its quality measures tracking and then determined to publicly report those results.

Over the past year, SETMA has expanded our quality measurement to include:

1. Physician Consortium for Performance Improvement (PCPI) quality measures for hypertension, diabetes, congestive heart failure, chronic renal disease, chronic stable angina, acute coronary syndrome, and others.
2. National Quality Forum (NQF) quality measures for diabetes, preventive healthcare, older adult care and many others.
3. Healthcare Effectiveness Data and Information Set (HEDIS)
4. Ambulatory Care Quality Alliance (AQA)
5. Physician Quality Reporting Initiatives (PQRI)
6. SETMA Quality Audits for Lipid Management and Chronic Renal Disease Stage I-III

These quality measures are designed and displayed in the EMR so that SETMA providers can measure their own performance at the time of their seeing patients. This makes it possible for SETMA providers to improve their own performance which is the principle reason for creating these functionalities to begin with. In our December 3, 2009 Your Life Your Health article entitled, "Transforming Healthcare: Public Reporting of Provider Performance on Quality Measures," we identified six reasons for public reporting; they are:

- First, we want to know what we are doing. Without auditing our performance, we will never know how we are performing. The COGNOS Project will allow us to objectify our performance. We will no longer "think" we are doing well; we will know if we are doing well and so will our patients and our community.
- Second, we want to improve what we are doing. Evidenced-based medicine, with the treatment targets established by science, can tell us where we want to be. If we know where we are and if we know where we want to go, we can design a way to get there.
- Third, when we know that a patient is not treated to target or to goal, we want to know why. COGNOS will allow us to know if evidenced-based standards of care are being employed. If they are, and if the patient is still not to goal, it will allow us to address hindrances and/or obstacles to the patient getting to goal.
- Fourth, we want to change provider behavior. The medical literature is replete with evidence of "treatment inertia," the nature inclination of people, even well-intentioned people, not to change things. Change requires that there be more pain or discomfort in staying the same as is required to make a change. SETMA believes that comparing provider performance and publishing that performance internally by patient name and externally as an aggregate practice performance will motivate providers to change.
- Fifth, we want to change patient behavior. Like the frog dropped into a kettle of cool water which is then placed on the fire, changes in a patient's health are often so subtle and so slow that devastation overtakes them before they realize they are sick. SETMA has used and intends to expand the use of patient data, through the COGNOS Project; to create discomfort in patients to make them "jump out of the heating kettle" of deteriorating health before it is too late.
- Sixth, we want to examine through statistical methodology and epidemiologic-principles patterns of care and outcomes. We want to be able to ask questions and analyze our data to get answers both retrospectively and then prospectively to those questions.

Public Reporting of SETMA's Performance: Where Can you find it?

SETMA is ready to do it's first Public Reporting of treatment results. The following reports were deployed January 22, 2010 on www.jameslhollymd.com:

- PCPI Diabetes
- PCPI Hypertension
- NQF
- HEDIS

These reports can be found by going to Public Reporting and then clicking on the drop down navigation button of the same name. The group of quality measures are first described then

illustrated and at the bottom of the screen there is a section entitled "Public Reporting – Current Reports." By clicking on these links, the treatment results will be displayed. Some of the measures are not yet reported because the tools for capturing the data have only recently been developed. Others will be added to the website soon.

Public Reporting and Practice Management

No one undertakes a project like this without some angst. There is no pattern to follow as we don't know anyone who has done or who is doing what we have undertaken. Second, what is being reported is a process and not a finished product. To this end, the following is a note which was sent to SETMA providers last week:

> "Attached are results for the Physician Consortium for Performance Improvement (PCPI) for Diabetes Management for SETMA providers from October 1 to December 31, 2009. These and other measures will go up on our website today at www.jameslhollymd.com under Public Reporting. We believe that over the next year, we will see dramatic improvement as providers learn:
>
> 1. How to make sure that they are documenting their work in order to get credit for their performance.
> 2. Attend to Chronic illnesses at the same time a patient is seen for an unrelated acute or chronic issue.
> 3. Redesign their personal workflow in order to make sure that quality measures are addressed.
>
> "Our intent is that these reports will be for educational and motivation purposes and not for punitive purposes. Being among the first to voluntarily publicly report results and doing it over as extensive an area of patient concern, as we intend, is daunting and some would say 'risky,' but we believe the positive benefits to our patients, our practice and our profession will far outweigh any such imagined or potential risk.
>
> "It is our expectation that we will report results quarterly. As we expand our COGNOS Project (for more information on that, see www.jameslhollymd.com under Public Reporting, COGNOS Project), it will be possible for our providers to utilize a 'digital dashboard' to 'drill down' into this data, to further evaluate how they can improve their results.
>
> "For instance, when it is seen that 5%+ of patients with diabetes have not had a Hgb A1C in the past six months, it will be possible for the provider to query the system and ask:
>
> 1. Were these patients not seen, or were they seen and a HgbA1C was not done?
> 2. Is the patient's diabetes so well controlled over such a long period of time that it is excessive to measure the HgbA1C more often than ever 9-12 months?
> 3. Are there patients whose charts indicate they have diabetes but who in fact do not?

> "It will be possible then for the provider to initiate correspondence either by e-mail or letter to the patients whose care is deficient to have them seen. These are unchartered waters but we believe the water is deep, the obstacles are few and the sailing will be smooth."

The key to finishing is starting

One of my favorite, personal axiom is: "I have started many things that I did not finish but I have never finished anything that I did not start." Simplistic? Yes, but absolutely true. We have started. I expect that a year or ten years from now, we will look back on this effort and think how simply we began, but the key is we have begun.

Part of SETMA's lore is an experience we had in May, 1999, four months after starting the use of the EMR. A description of that experience concludes the introduction to our website's new EPM-Tools Section's Introduction. It expresses our philosophy and motivation for this new and at present incomplete function to our website:

"Celebration "It was in May, 1999, that we had a sentinel event which has continued to define our efforts in development of EPM. In that month, my co-founding partner, Dr. Mark Wilson, speaking of where we were in the use of the EMR, lamented, 'We haven't even begun to crawl.' He was discouraged and worried that we had bought a very expensive and useless toy.

"I responded, 'Mark, when you oldest son turned over in bed, did you call you wife and say, "this retarded child can't even crawl all he can do is turn over in bed?" Or, did you cry out, "Come see, he turned over in bed?" The reality is that you celebrated his turning over in bed. You expected him to crawl and to walk, in due time, but right now you enjoyed his progress. So shall I; you're right; we aren't even crawling but we have started. If in a year, all we're doing is what we are presently doing, I will join your lamentation, but until then I am going to celebrate that we have begun.'"

Transforming Healthcare with the power of information and with the power of auditing

Perhaps the greatest problem in healthcare is that change which helps or harms a patient takes place over a long period of time. Learning to see slow, gradual processes requires slowing down our frenetic pace and paying attention to the subtle as well as the dramatic. The slowly boiled frog does not react to the slowing heating water because the frog does not become uncomfortable until the damage has already been done.

The slow "boiling" which comes from the deterioration of health requires a new methodology for effecting change in patient and provider behavior. Part of that will be achieved by enhancing the capability of a healthcare provider to create discomfort in the patient in order to effect change which will benefit the patient in the long run. Part of that will be achieved by the creation of discomfort in the provider via self-auditing at the point of care which allows the provider to measure his/her performance against an accepted standard.

Because the processes which ultimately destroy health are mostly painless and are invisible, effective intervention requires making the effect of those processes apparent. Data display, which is longitudinal (over time for the same patient) and comparative (show in contrast to the results of other patients), can create discomfort in the patient and provider, which discomfort can contribute to change.

Public Reporting – Provider Improvement – Patient Health

We believe that public reporting will result in provider improvement and ultimately in benefit to our patients. As you review our published results today, join us in celebrating that we have begun. And, expect with us that one year form now we will see a remarkable improvement in both our performance and in the health of our patients.

Medical Home: Questions About Our Journey
By James L. Holly, MD
Your Life Your Health
The Examiner
April 8, 2010

The following is a series of question which were presented to SETMA by a national organization about our 14-month pilgrimage to becoming a Patient-Centered Medical Home (PCMH). On the date of this article's publication, SETMA will have submitted an application to the National Committee for Quality Assurance (NCQA) for recognition as a PCMH. In is our hope to obtain a Tier-3 recognition which is the highest.

1. What motivated your organization to become a Patient Centered Medical Home?

In 1997, SETMA realized that we either had to learn the new method of managed healthcare, or be bypassed by a new healthcare delivery model. In spite of initially thinking that managed care was intrusive to the patient/physician relationship, we learned how to practice efficient, cost-effective medicine, while at the same time retaining excellent personal relationships with our patients.

In 1998, we adopted the NextGen EMR and EPM products. In May, 1999, only three months after we launched our use of NextGen, we realized that what we needed was "electronic patient management" (EPM, for more on this concept see the EPM section on our website at http://www.jameslhollymd.com and the articles on EPM under Your Life Your Health) more than electronic patient records. This set us about the designing of disease management tools, doing population management, pursuing quality improvement and integrating all aspects of care delivered at our clinic, hospital, nursing home, physical therapy, hospice, home health, laboratory and other healthcare-delivery functions.

Even as the concept of PCMH became more and more main stream, we were as ignorant of what it meant as we were about managed care thirteen years ago. To show how dynamic this environment is even as PCMH is being accepted, its name is changing into "Health Home," to reflect the expansiveness of the relationship to include many professionals beyond physicians, CNFPs and nurses

After attending a PCMH lecture on February 16, 2009, which lecture was confusing and unhelpful, SETMA decided to take the same approach as we had with managed care. Over a one-month period we did a thorough analysis of our practice based on CMS' 28 principles of PCMH. In that process, we produced a 400-page analysis of our practice in which we identified the things we were doing which reflected the ideals of PCMH and the PCMH functions we were lacking. We then took the 9 Standards, 30 Elements and 183 data points of NCQA's PCMH model and did the same analysis.

By March, 2009, our judgment was that PCMH was a logical extension of what we had been working on for thirteen years. We began thinking and writing about PCMH (all of which is on our website www.jameslhollymd.com) and we published all of our electronic patient

management tools on the site as well as publishing our Public Reporting of provider performance on quality measures there. Our early impressions about PCMH grew into a vision and then became a passion. We concluded that this was what we had been working toward all along, even when we didn't know what to call it.

2. What are the three key points of value from becoming a PCMH?

1. Creating "intentionality" about quality, excellence, coordination and integration of our patients' healthcare rather than "coincidently" achieving parts of each (For more on this concept see "Medical Home Part IV: Help and Hope in Healthcare" March 12, 2009 at www.jameslhollymd.com under "Your Life Your Health). In that article, it is stated:

   > "The most innovative aspect of Medical Home and the thing which distinguishes it from any other well-organized and highly-functioning medical organization is the concept of 'Coordination of Care'. This is the intentional structuring, reviewing, facilitating and practicing of a standard of care which meets all current NCQA, CMS,NQF, PCPI, AQA, and HEDIS requirements for demonstration of excellence in the providing of care.
   >
   > "The concept of 'intentionality' is critical in this process. This is contrasted with "incidental." In healthcare, most HEDIS compliance and coordination of care are done coincidental to a patient encounter as opposed to the having of a purposeful, provable and persistent method of fulfilling of national standards of care. Rather than hoping the result is good, 'Coordination of Care' plans and reviews care to make certain that it meets the highest standards.
   >
   > "The Medical Home intentionally fulfills the highest and best healthcare needs of all patients. In addition, the patient is involved in this coordination by our making them aware of the standards and giving them a periodic review, in writing, of how their care is or is not meeting those standards. Patients are encouraged to know and to initiate the obtaining of preventive care on their own.
   >
   > "Perhaps the ultimate judge of the success of Medical Home is when healthcare providers hear the following from their patients, 'I am here today for preventive healthcare.' Today, almost all healthcare providers would tell you that they have never had a patient present with that 'chief complaint,' or reason for scheduling an appointment."

2. Team -- The challenge to create a healthcare team with the patient and all healthcare professionals as members of that team. It is the realization that if the one in charge of a patient's healthcare is characterized as the one with the "baton," the patient has the baton for the majority of the time. (For more on this concept see "Passing the Baton: Effective Transitions in healthcare Delivery", March 10, 2010 on our website at www.jameslhollymd.com under "Your Life Your Health). In that article it is stated:

"Athletic metaphors are commonly used in analyzing life situations. Often they are overstated and/or overused, but there is one place where an athletic metaphor is apt in defining a critical point in healthcare. That is in the 'transitions of care' from one venue of care to another. The metaphor is found in track and field relay races.

"No matter how talented the members of a relay team are, the most critical point of their collective performance is in the transition of the race from one runner to another. At this point, one runner, moving as fast as he/she can, must hand the baton to another runner, who has started running as fast as he/she can, before the first runner has even arrived in the "transfer zone." As if this were not complex enough, the rules of the race require that the transfer of the baton must take place within a certain zone.

"If the baton is dropped or if the transfer is not made in the prescribed time, the team, no matter how gifted, will be disqualified and will lose the race. As with life and with healthcare, it is not always the brightest, fastest, or best person who wins. It is the person, in this case, the team, which not only performs well in their individual area of responsibility but who also performs well in transferring the results of his/her performance to the next participant and who does so within the constraints of the rules. ***Often, it is forgotten that the member of the healthcare delivery team who carries the 'baton' for the majority of the time is the patient and/or the family member who is the principal caregiver. If the 'baton' is not effectively transferred to the patient or caregiver, then the patient's care will suffer."***

3. It is to discover the true implications of SETMA's motto which we adopted in August, 1995, which states, "Healthcare Where Your Health is the Only Care." It is to put the patient and their needs first. SETMA has done that in many ways. We developed The SETMA Foundation through which we help provide funding for the care of our patients who cannot afford it. In 2009, SETMA's partners gave $500,000 to the foundation We had one patient whose teeth were so rotten that her entire health was deteriorating. The Foundation paid the $10,000 needed to "fix" the problem. It has transformed her life.

   Another patient who came to the clinic angry, hostile and bitter was found not to be a bad person but depressed because he could not work, could not afford his medication and was losing his eye sight. He was depressed. He left the clinic with The Foundation buying all of his medications, giving him a gas card to get to our ADA certified DSME program, the fees waived for the classes, help in applying for disability, and an appointment to an experimental program for preserving the eyesight of patients with diabetes. He returned in six weeks with something we could not prescribe. He had hope and joy. By the way, his diabetes was to goal for the first time in years. This is PCMH and it is humanitarianism. They may be the same thing.

4. How has health IT enabled your organization to fulfill the requirements of the PCMH?

Without IT, SETMA could not address the complex patient-care issues which are required by 21st Century, technological healthcare, not to mention the complex needs of patients with multiple diseases. IT has allowed us to imbed hundreds of quality metrics – both process and outcomes – into our EMR, making it "easier to it right than not to do it at all." We daily and individually track all HEDIS measures on every patient. We participate in PQRI tracking far more quality metrics than those required. We measure Ambulatory Care Quality Alliance (AQA) standards. We track the Physician Consortium for Performance Improvement (PCPI) metrics for diabetes, hypertension , CHF, Chronic Stable Angina, Chronic Renal Diseases, etc. And, where no agency, or organization has endorsed quality measures, such as for Lipids and Chronic Renal Disease State I-III, SETMA wrote our own. We are able to look at patient populations by practice or provider to see longitudinally whether their treatment is to goal and to compare those who are not at goal with those who are. This allows us to see if patterns of care emerge which allow us to improve everyone's care. We are able to look at populations from socio-economic and ethnic perspectives to make sure we have eliminated disparities in care which traditionally afflict these groups.

Without IT, we could not practice the standard of healthcare to which we aspire.

4. How has quality been transformed in your organization and what role has health IT played? For instance, the ability to measure, monitor, trend?

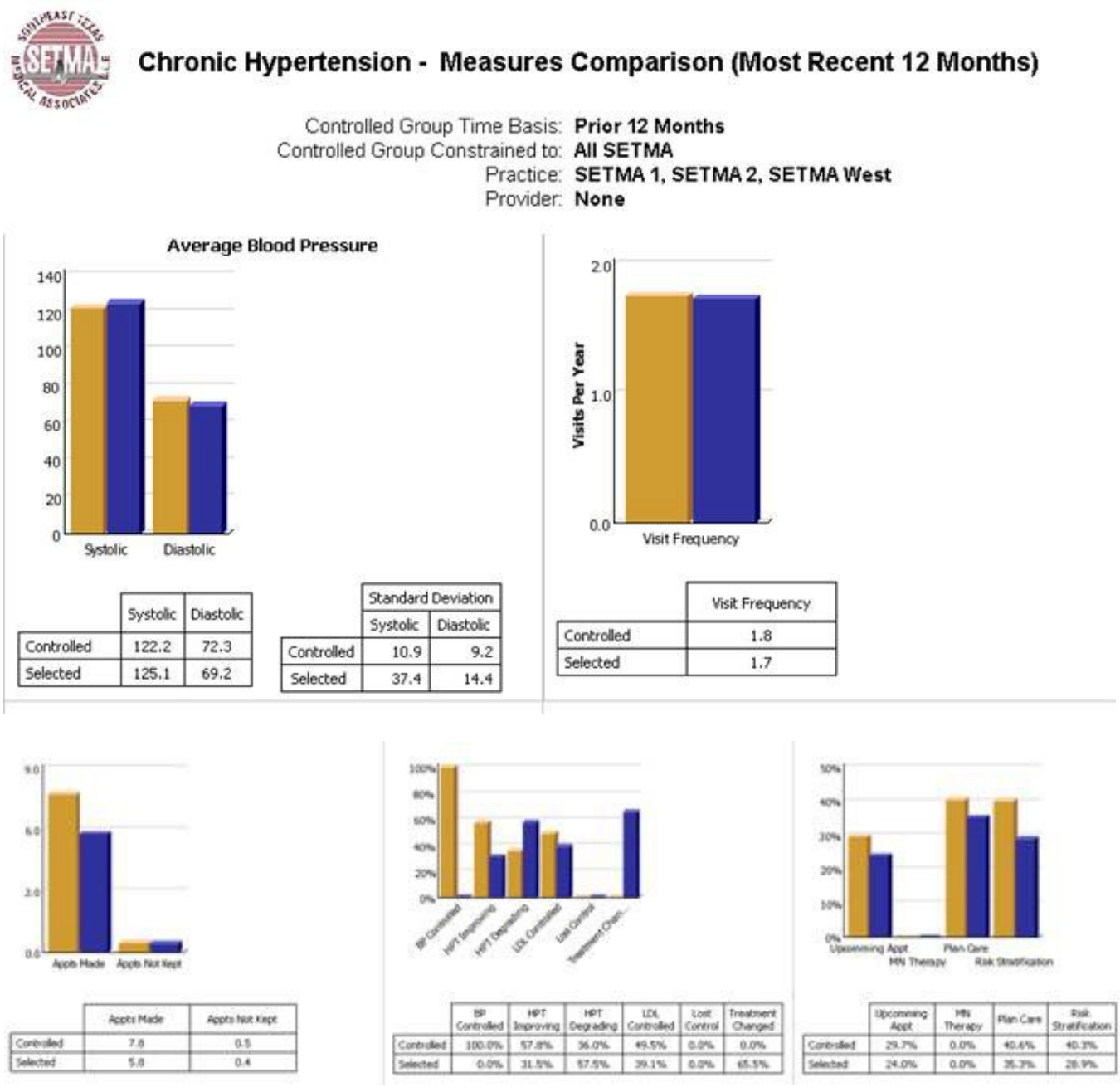
Using digital dashboard technology, SETMA analysis provider and practice performance in order to find patterns which can result in improved outcomes practice wide for an entire population of patients. We analyze patient populations by:

- Provider Panel
- Practice Panel
- Financial Class – payer
- Ethic Group
- Socio-economic groups

We are able to analyze if there are patterns to explain why one population or one patient is not to goal and others are. WE can look at:

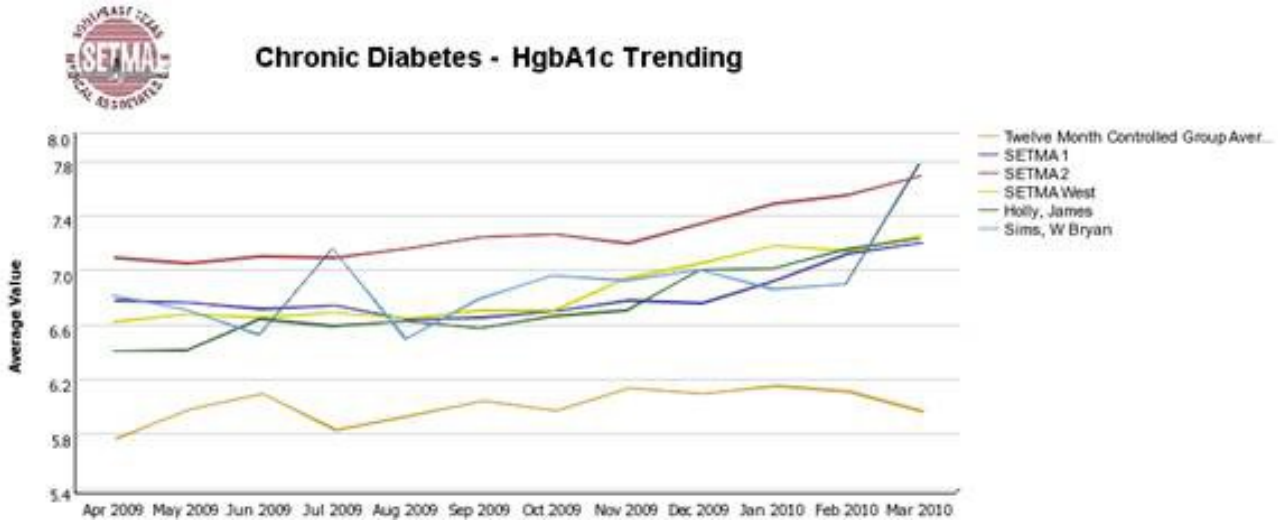
- Frequency of visits
- Frequency of testing
- Number of medications
- Change in treatment
- Education or not

- Many other metrics



We are able to present over-time patient results comparing:

- Provider to practice
- Provider to provider
- Provider current to provider over time
- Trending of results to see seasonal changes, etc.



5. What are your next steps, and how will health IT factor into your success?

Keep dreaming and moving forward. Change in healthcare is like breathing, it is inevitable and essential. We will add to our auditing ability. We will add functions to our patient care. We will find innovative ways of solving complex problems. We will participate in the transformation of healthcare and healthcare IT, which in ten years will be very much different than it is now. For instance with the human genome detailed and with more and more genetic foundations for disease being discovered, we believe that in ten years or less, it will be necessary to have medical informatics capabilities to store, analysis and to utilize each patient's genome in their treatment. That is a huge data-base task which we are already discussing and designing solutions for. We will all get there one step at a time. At times we will lead the development and at other times we will follow the lead of others. Together, we will change.

6. What tips would you provide to others in preparing for and going through the process?

- Get started! In my life, I have started many things which I never finished, but I have never finished anything I didn't start. No matter how daunting the task, the key to success is to start.
- Compete with yourself, not others! In his book, *If Aristotle Ran General Motors*, Tom Morris states, ""I do not try to dance better than anyone else. I only try to dance better than myself – Mikhail Baryshnikov." It doesn't matter what someone else is or is not doing; set your goal and pursue it with a passion. Measure your success by your own advancement and not by whether someone else is ahead or behind you. In the same way, share your success with others. In helping others succeed, you will find true fulfillment.
- Don't give up! The key to success is the willingness to fail successfully. Every story of success is filled with times of failure but is also characterized by the relentlessness of starting over again and again and again until you master the task.. When we started our IT project, we told people about what we are doing.

We call that our “Cortez Project”. Like Cortez, we scuttled our ships so there was no going back. We had to succeed.

- Have fun! Celebrate! Enjoy what you are doing and celebrate where you are. In May of 1999, my co-founding partner of SETMA lamented about our EMR work; he said, “We are not even crawling yet.” I said, “You are right but let me ask you a question. ‘When your son turned over in bed, d id you shout and say to your wife, “this retard, dimwitted brat can’t even crawl, all he can do is turn over in bed?” Or, did you shout to your wife, “He turned over in bed?” Did you celebrate his turning over in bed?” He smiled and I added, “I am going to celebrate that we have begun. If in a year, we aren’t doing more, I will join your lamentation, but today I celebrate!” We have had a celebratory spirit since that day and we have gone from success to success.

You may note that none of these tips have to do with process or content but with attitude and “frame-of-mind.” These are the elements of success. The process and content are easy.

In addition to the six questions above, if you have any additional materials, guidance and/or knowledge to share, it would certainly be appreciated.

Our website site has an eleven-part series on PCMH. That series reflects our growth and development. Other materials there (under Your Life Your Health) show how we continue to learn and to grow. Under Medical Home at www.jameslhollymd.com we display the tools we have developed and will continue to post new tools that we develop. Under EPM, we display all of our electronic patient management tools. Under Public Reporting, we display our providers’ performance on all of the quality measures we are following.

In many ways, SETMA has only begun, but wherever we are, we are celebrating, having fun and desiring to help others succeed.

Patient-Centered Medical Home:
The Power of Data in Designing the future of healthcare
By James L. Holly, MD
Your Life Your Health
The Examiner
May 20, 2010

(Editor's Note: On May 12-14, Dr. Holly was in New York City participating in a Medical Leadership Conference on Medical Information Technology sponsored by NextGen@, the producer of the electronic medical record system which SETMA has used for the past twelve years. The following is an edited version of the address which he made to the conference.)

The Reality

The only care which benefits a patient is the care which they can access. Though I know all there is to know about treating a complex medical condition, only the care the patient can afford or can obtain improves their health. This reality has major medical, social, political and economic implications.

On February 16, 2009, this writer attended a conference in Houston on Patient-Centered Medical Home. As I drove to the conference, I said to my colleagues, "If I am going to listen to someone read a power-point presentation to me, I am going to be aggravated." I was aggravated. I came away from the lecture knowing no more about what Patient-Centered Medical Home really is than I did before.

The next morning, while making rounds, I met the incarnation of "medical home." That incarnation was in the form of an angry, frustrated, hostile, and belligerent patient. Nothing I could say dissuaded this person from their anger. As a result, I asked the patient to see me personally in follow-up. Keeping the office appointment, het was no different, but in the visit I discovered the following:

1. The patient was disabled and could not pursue his job.
2. The patient was taking only four of his nine mediations as he could not afford all of them.
3. The patient was losing his eyesight due to his underlying illness.
4. The patient could not afford the gas to come to education class which might help him improve his health.
5. The patient could not afford the co-pays for education classes.

After evaluating the conditions for which he was hospitalized, he left with the following:

1. All of his medications, paid for by the SETMA Foundation, a 501-C3 foundation established by the partners of SETMA to help their patients receive the care they need. In 2009 alone, SETMA partners contributed $500,000 to the Foundation.
2. A gas card from the foundation so that he could afford to come to education classes.
3. The co-pays waived for the education classes.
4. Help in applying for disability income.

5. Referral by SETMA's Ophthalmologist to a research program in Houston which could help preserve his eyesight.

Though we did not yet understand all there was to know about Patient-Centered Medical Home, we recognized that we had just experienced it. Six weeks later, this patient returned with a smile on his face and with his winsome personality apparent. He had something we could not prescribe. He had hope and his illness was treated to goal for the first time in several years.

Address to Graduating Class at School of Medicine

On May 22, 2010, this author will give his last greeting as President of the Alumni association to the graduates of the University of Texas Health Science Center at San Antonio School of Medicine. That greeting incorporates many of the realities of healthcare today. It states:

"As you stand today to receive the symbol of a lifetime of achievement -- your doctor of medicine diploma. -- you stand on one hundred years of progress since Abraham Flexner challenged the nation with the need for a sound scientific foundation to the teaching and practice of medicine. Today crowns "a lifetime of achievement", for your medical education did not begin four years ago, nor will it end today.

"Without doubt you are the smartest and most knowledgeable generation of physicians ever, and you fulfill every hope and expectation of the 1910 Flexner report. Yet, contained in that report was a potential unintended consequence: the possible replacement of a personal, trusting physician/patient relationship with a trust only in technology.

"You face the reality that the only care which will improve the health of your patients, while based on your knowledge, is the care they are able to access and receive. You face the dilemmas created by the success of scientific progress, which are:

- "How do I balance technology with humanity?"
- "How do I overcome the seduction of entrepreneurism which has eaten at the soul of medical professionalism like a cancer?
- "How do I re-establish patient confidence in my counsel, supported by appropriate technology, rather than my patients simply trusting in more procedures, tests and operations?
- "How do I balance the tension between more care and more health?"

"As your President, I welcome you to your alumni association. Your school and your colleagues need your participation and support. Welcome to the future of a profession which not only desires to help others to live longer but to help them have a life every day they live.

"Today, we pass the healthcare leadership baton to your generation of physicians. We will carry it with you part of your journey, but if we all are to succeed, our hopes and passions must be incorporated into yours. We pass this baton to you confident of your fidelity to the profession you join and to the vision and mission of your University.

Congratulation and welcome to the task."

Steps of Designing the Future

The following are the steps of the designing of the future of excellence in the delivery of healthcare; they are:

1. Provider Performance Tracking with the ability for Providers to Evaluate their Own Performance at the Point of Care
2. Auditing of Provider Performance through SETMA's COGNOS Project
3. Analysis of Provider Performance through Statistics
4. Public Reporting of Provider Performance
5. Quality Assessment and Performance Improvement

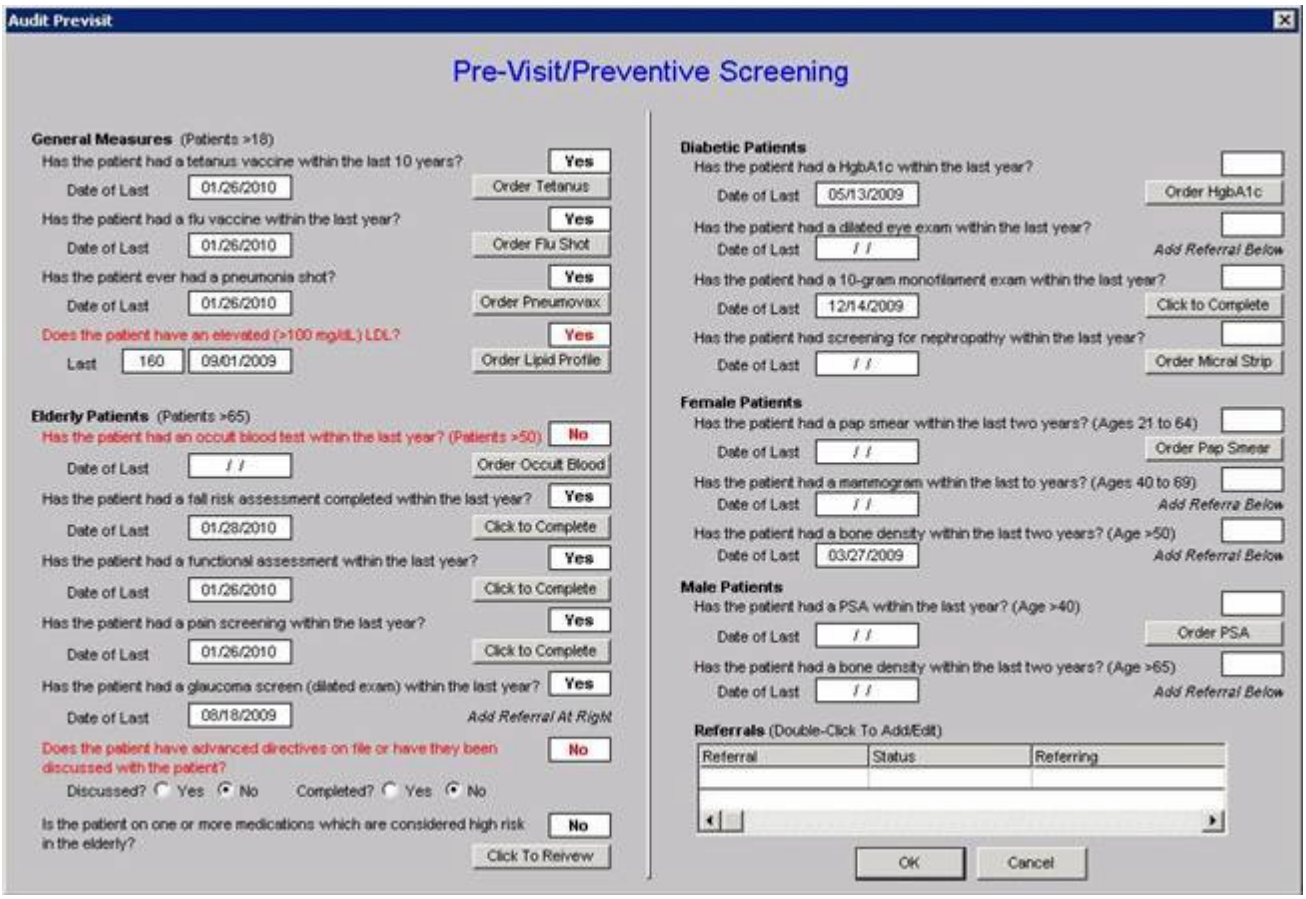
Regular readers of this column will recognize these steps. For others, the following discussion will help and references will be given to where more can be found about each of these steps.

Provider Performance Tracking

The Physician Consortium for Performance Improvement (PCPI) is an organization created by the AMA, CMS, Institute of Medicine and others to develop measurement sets for quality assessment. The intent is to allow healthcare providers to evaluate their own performance at the time they are seeing a patient. SETMA is tracking a number of these measurement sets including: Chronic Stable Angina, Congestive Heart Failure, Diabetes, Hypertension, and Chronic Renal Disease Stages IV through ESRD, Adult Weight Management, and Care Transitions. Others will be added overtime. The details of these measurement sets and SETMA's provider performance on each can be found at www.jameslhollymd.com under ***Public Reporting PCPI***.

In addition to Provider Performance Tracking tools such as those produced by PCPI, the National Quality Foundation (see www.jameslhollymd.com under Public Reporting NQF), and National Committee for Quality Assurance (see www.jameslhollymd.com under Public Reporting HEDIS and/or NCQA), SETMA has designed a pre-visit quality measures screening and preventive care tool. This allows a SETMA provider and a patient to quickly and easily assess whether or not the patient has received all of the appropriate preventive health care and the appropriate screening health care which national standards establish as being needed by this patient.

The following is the Pre-visit Preventive Screening tool. All measures in black apply to the current patient and are fulfilled. All measures in red apply to the current patient and have not been fulfilled and all measures in grey do not apply to the current patient.
If a point of care is missing, it can be fulfilled with the single click of a single button.



While healthcare provider performance is important for excellent care of a patient's health, there are 8,760 hours in a year. A patient who receives an enormous amount of care in a year is in a provider's office or direct care less than 60 hours a year. This makes it clear that the patient is responsible for the overwhelming amount of their own care which includes compliance with formal healthcare initiatives and with lifestyle choices which support their health.

If responsibility for a patient's healthcare is symbolized by a baton, the healthcare provider carries the baton for .68% of the time. That is less than 1% of the time. The patient carries the baton 99.22% of the time. The coordination of the patient's care between healthcare providers is important but the coordination of the patient's care between the healthcare providers and the patient is imperative. (For more on this concept see: *Passing the Baton: Effective Transitions in Healthcare Delivery* By James L. Holly, MD Your Life Your Health *The Examiner* March 12, 2010 at www.jameslhollymd.com)

The following is a direct quote from this article. The emphasis and italics appear in the original:

"Often, it is forgotten that the member of the healthcare delivery team who carries the 'baton' for the majority of the time is the patient and/or the family member who is the principal caregiver. If the 'baton' is not effectively transferred to the patient or caregiver, then the patient's care will suffer."

Auditing of Provider Performance – SETMA's COGNOS Project

The creating of quality measures is a complex process. That is why it is important for agencies such as the Ambulatory Care Quality Alliance (AQA), the NCQA, the NQF, the Physician Quality Reporting Initiative (PQRI) and PCPI, among others, to identify, endorse and publish quality metrics. The provider's ability to monitor their own performance and the making of those monitoring results available to the patient is important, but it only allows the provider to know how they have performed on one patient. However, the aggregation of provider performance over his/her entire panel of patients through an auditing tool carries the process of designing the future of healthcare delivery a further and a critical step.

Auditing of provider performance allows physicians and nurse practitioners to know how they are doing in the care of all of their patients. It allows them to know how they are doing in relationship to their colleagues in their clinic or organization, and also how they are performing in relationship to similar practices and providers around the country.

As a result, SETMA has designed auditing tools through the adaptation to healthcare of IBM's business intelligence software, COGNOS. Multiple articles on SETMA's COGNOS Project can be found at www.jameslhollymd.com under ***Your Life Your Health*** and the icon ***COGNOS***. Those discussions will not be repeated here but auditing is an indispensable tool for the improvement of the quality of healthcare performance and for improvement in the design of healthcare delivery.

Through COGNOS, SETMA is able to display outcomes trending which can show seasonal patterns of care and trending comparing one provider with another. It is also possible to look at differences between the care of patients who are treated to goal and those who are not. Patients can be compared as to socio-economic characteristics, ethnicity, frequency of evaluation by visits and by laboratory analysis, numbers of medication, payer class, cultural, financial and other barriers to care, gender and other differences. This analysis can suggest ways in which to modify care in order to get all patients to goal.

Analysis of Provider Performance through Statistics

Raw data can be misleading. It can cause you to think you are doing a good job when in fact many of your patients are not receiving optimal care. For instance the tracking of your average performance in the treatment of diabetes may obscure the fact that a large percentage of your patients are not getting the care they need. Provider Performance at the point of service is important for the individual patient. Provider Performance over an entire population of patients is important also. However, until you analyze your performance data statistically, a provider will not know how well he or she is doing or how to change to improve the care they are providing..

Each of the statistical measurements which SETMA tracks, the mean, the median, the mode and the standard deviation, tells us something about our performance. And, each measurement helps us design quality improvement initiatives for the future. Of particular, and often, of little known importance is the standard deviation.

From 2000 to 2010, SETMA has shown annual improvement in the mean (the average) and the

median results for the treatment of diabetes. There has never been a year when we did not

improve. Yet, our standard deviations revealed that there were still significant numbers of our patients who are not being treated successfully. Even here, however, we have improved. From 2008 to 2009, SETMA experience a 9.3% improvement in standard deviation. Some individual SETMA providers had an improvement of over 16% in their standard deviations. Our goal for 2010 is to have another annualized improvement in mean and in median, and also to improve our standard deviation. When our standard deviations are below 1 and as they approach .5, we can be increasingly confident that all of our patients with diabetes are being treated well.

An example of a statistical analysis of SETMA's diabetes care in regard to the elimination of ethnic disparities of care is given in the article *Eliminating Ethnic Disparities in Diabetes Care* Your Life Your Life Your Health *The Examiner* May 13, 2010, which is posted on our website at www.jameslhollymd.com.

Public Reporting of Provider Performance

One of the most insidious problems in healthcare delivery is reported in the medical literature as "treatment inertia." This is caused by the natural inclination of human beings to resist change. Often, when patients' care is not to goal, no change in treatment is made. As a result, one of the auditing elements in SETMA's COGNOS Project is the assessment of whether a treatment change was made when a patient was not treated to goal.

Overcoming "treatment inertia" requires the creating of an increased level of discomfort in the healthcare provider and in the patient so that both are more inclined to change their performance. SETMA believes that one of the ways to do this is the pubic reporting of provider performance. That is why we are publishing provider performance by provider name at www.jameslhollymd.com under

Public Reporting.

A more complete explanation of SETMA's philosophy and intent in "public reporting" of provider performance can be found in the following articles:

- *Transforming Healthcare Public Reporting of Provider Performance on Quality Measures* Your Life Your Health December 3, 2009;
- *Patient-centered Medical Home SETMA's COGNOS Project Changing Patient and Provider Behavior* Your Life Your Health October 29, 2009.
- *County Health Rankings – Part II Quality of Care – What Will Be Gained by Public Reporting* Your Life Your Health March 4, 2010

QAPI – Quality Assessment and Performance Improvement

Quality Improvement Initiatives based on tracking, auditing, statistical analysis and public reporting of provider performance are critical to the transformation of healthcare both as to quality of care and as to cost of care.

With the above described data in hand and with the analysis of that data, it is possible to design quality initiatives for future improvement in care. Currently SETMA is designing two major quality initiatives. One is for diabetes. It is an attempt to eliminate the last vestiges of ethnic disparity in the care of diabetes. This will require the use of additional internal resources and attention but it is our intent to do so and to permanently and totally eliminate ethnic disparities. The other is in regard to decreasing avoidable readmissions to the hospital.

The details of these two initiatives can be reviewed at www.jameslhollymd.com :

- *Designing a Quality Initiative: How? Hospital Re-admissions* Your Life Your Health April 22, 2010.
- *Eliminating Ethnic Disparities in Diabetes Care* Your Life Your Life Your Health May 13, 2010

Without a systems approach to healthcare, each of these steps are impossible; certainly, the analysis and transformation of healthcare is impossible. With a systems approach, this logical and sequential process is possible and rewarding for provider and patient. This process has set SETMA on a course for successful and excellent healthcare delivery. Our tracking, auditing, analysis, reporting and design will keep us on that course.

SETMA and the National Quality Forum
By James L. Holly, MD
Your Life Your Health
The Examiner
November 11 2010

In addition to the other activities for improving healthcare, SETMA has become a member of the National Quality Forum. As SETMA prepared to apply to the National Committee for Quality Assurance (NCQA) for recognition as a Patient-Centered Medical Home (SETMA was awarded a Tier III recognition in July, 2010), which designation is a registered trademark of NCQA, we were confronted with the requirement that we report to our providers and to at least one external organization our performance on ten quality measures endorsed by the National Quality Forum (NQF). In February, 2009, we had never heard of the NQF.

Thus began our journey into understanding both the science of "quality metrics" and to our participation in the work of NQF. This statement does not imply that SETMA is an expert in the field of quality metrics, or that we currently play a significant role in the NQF, but we do continue to increase our understanding of quality metrics and our participation in NQF. NQF defines itself as, "a unique, multi-stakeholder organization instrumental in advancing efforts to improve quality through performance measurement and public reporting...(and as) a private, not-for-profit membership organization with more than 400 members representing virtually every sector of the healthcare system."

The following is a brief history of NQF. In 1998, A report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, proposed the formation of the Forum as a part of a national agenda for improvement in healthcare delivery. Formed in 1999, NQF's declared:

> "The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs."

NQF's vision is to be, "the convener of key public and private sector leaders to establish national priorities and goals to achieve the Institute of Medicine Aims—health care that is safe, effective, patient-centered, timely, efficient and equitable. NQF-endorsed standards will be the primary standards used to measure and report on the quality and efficiency of healthcare in the United States. The NQF will be recognized as a major driving force for and facilitator of continuous quality improvement of American healthcare quality."

NQF (www.qualityforum.org)"is a voluntary consensus standards setting body as specified by the National Technology and Transfer Advancement Act of 1995 and OMB Circular A-119 (1998). NQF endorsement, which involves rigorous, evidence-based review and a formal Consensus Development Process, has become the "gold standard" for healthcare performance

measures. Major healthcare purchasers, including CMS, rely on NQF-endorsement to ensure measures are scientifically sound and meaningful and to help standardize performance measures used across the industry."

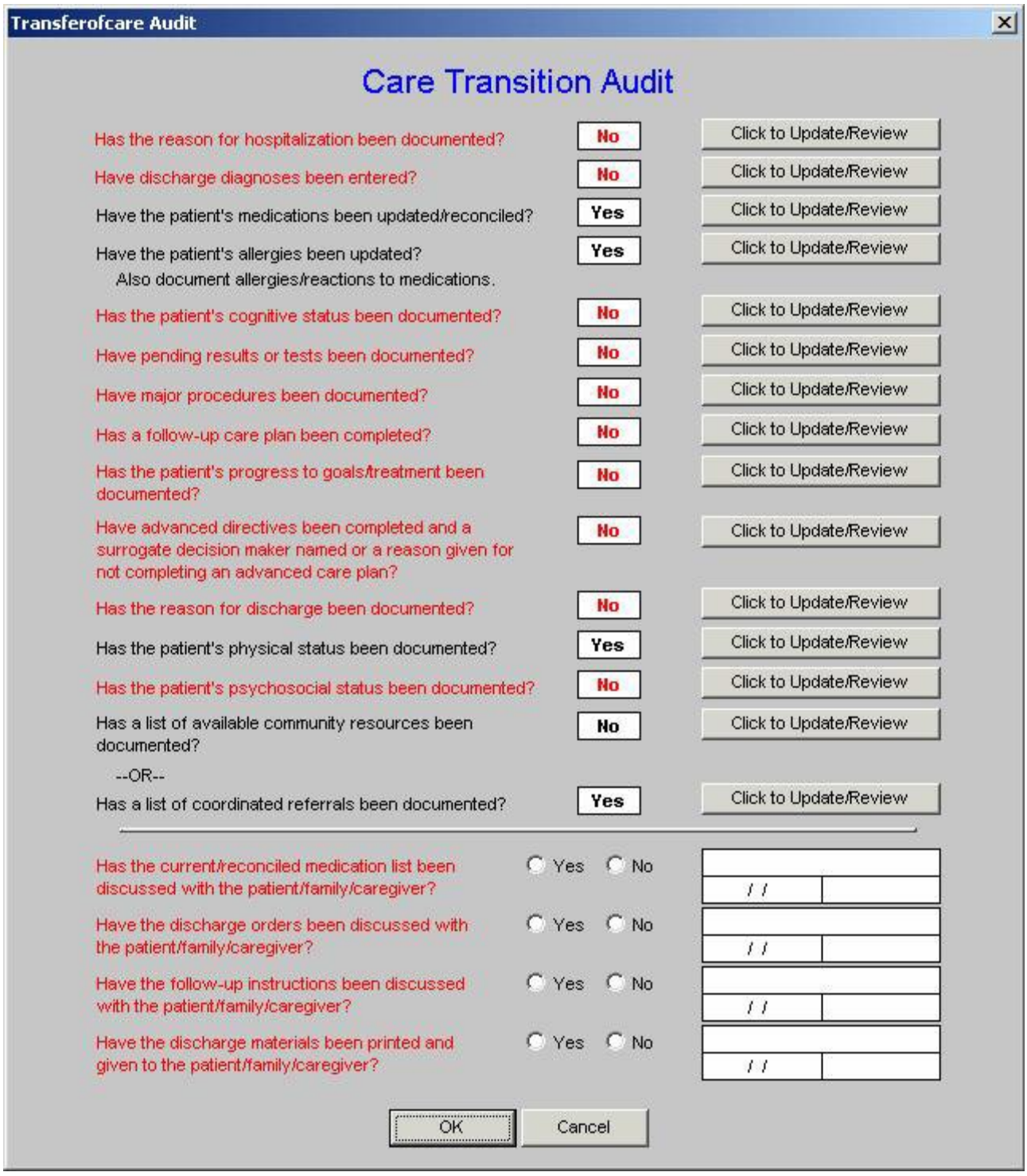
As of October, 2008, NQF had endorsed 514 "national voluntary consensus standards." As indicated above, for NCQA recognition as a medical home, a physician group must report to its providers and to an external agency their performance on at least ten measures. In 2009, SETMA began reporting on forty-three NQF-endorsed quality metrics and in 2010, added an additional twenty metrics to our reporting. In 2009, SETMA also began publicly reporting, on our website (www.jameslhollymd.com), by provider name, our performance on these and several hundred others quality metrics.

Care Transitions

In September, 2010, a NQF conference was held in Washington, D.C., entitled *National Priorities Partnership Care Coordination Convening Workshop*. Two of SETMA's colleagues scheduled to attend this meeting.

In June, 2009 the Physician Consortium for Performance Improvement (PCPI) published an 18-point quality metrics set entitled "Care Transitions." This measurement set addressed fourteen data points which were established as required in order to improve the care of patients being discharged from the inpatient, or the emergency department of the hospital. In addition to the data points, there were four actions which were required. When SETMA read this material in June, 2009, we released that we had been performing all but one of these quality measures for at least seven years. Therefore, we designed a tool through which to document the performance of these 18 quality metrics and through which to audit our performance on completing them. This PCPI Care Transitions measure set is one of the quality metric sets which we began publicly reporting on our website in late 2009.

SEMA's Care Transitions template is displayed below. As can be seen by reviewing the 14 data points and the 4 actions required by the audit, when the elements of this audit are met and when the discharge summary and follow-up document are completed with this material, and are given to the patient and/or family, almost all continuity of care issues are resolved. The legend is that everything in black is done and everything in red has not been done.



On August 24, 2010, I wrote the President of the NQF and said, “”SETMA’s Chief Medical Officer and I are registering to attend the NQF National Priorities Partnership on Care Transitions in Washington next week. I am a member of the HIMSS PS&CO committee and CEO of Southeast Texas Medical Associates, LLP, a medium size, multi-specialty practice in Beaumont, Texas. We have had experience with ‘care transition’ for the past 14 months and have designed a quality improvement initiative for decreasing avoidable readmissions to the

hospital employing 'care transitions' metrics, as well as other strategies (a preliminary description of this project is attached, entitled 'Designing A Quality Initiative How? Hospital Re-admissions.'"
NQF responded with the following invitation:

> "Thank you as well for sending along this useful and encouraging information on care coordination. I see you have registered as part of our audience, which is an open invitation extended to all NQF members. Allow me to offer you a formal initiation to attend the workshop as an invited content expert in this field and to participate in the round table discussions we will be having. Assuming this is agreeable we will send you along additional logistics."

During that conference, it became apparent that one fundamental flaw in healthcare is the name used for the hospital summary of care It is currently called a "discharge summary," and is essentially an administrative document required to complete the patient's record. However, when seen in its "real" purpose, this document would better be entitled, "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." SETMA has made that name change and is benefiting from the new and clearer understanding of the rationale for this document.

NQF membership

After our participation in the September, 2010 NQF conference, an invitation was extended for SETMA to consider becoming a member of NQF, which we did. As stated above by NQF policy, and as acknowledged by SETMA, any medical group can join the NQF and any member of the public can attend the open meetings of the NQF. The benefit of membership is that you will receive announcements of current work for which comment is solicited and you will also receive links to completed work, which is published for use in the healthcare industry. For SETMA, the benefit is that we are able to expand our understanding of the content of our transformation of our practice into a medical home, to increase our knowledge of the value and definition of quality metrics, and to broaden our participate in the national discussion about these critical matters in he future of healthcare.

This is illustrated by the notice SETMA received on November 1 with links to the following:

1. *Preferred Practices and Performance Measures for measuring and Reporting Care Coordination.*
2. *The ABCs of Measurement*
3. NQF Member and Public Commenting for *Driving Quality: A Model to measure Electronic Health IT use.*
4. Quality Connections and Care Coordination

The Executive Summary of this last publication states:

"Care coordination—a function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time—is foundational to high-quality healthcare. All patients, but especially the growing number of

Americans who suffer from multiple chronic conditions, can benefit from care coordination. Care coordination is an information-rich, patient-centric endeavor that seeks to deliver the right care (and *only* the right care) to the right patient at the right time. Unfortunately, the prevailing model of healthcare for most patients is poorly coordinated, to the detriment of the patient. This poses a threat to patients and the healthcare system in the form of heavy disease burden, safety concerns, and financial inefficiency.

"Essential elements of care coordination include a written plan of care that anticipates routine needs and actively tracks up-to-date progress toward a patient's goals, and a communications 'feedback loop' consisting of open dialogue among members of the care team, the patient, and his or her family. The 'healthcare home,' similar to but more expansive than the commonly known 'medical home,' is a promising model that may achieve truly coordinated care on a vast scale. The healthcare home is a single, coordinating source of usual care selected by the patient, such as a large or small medical group, a single practitioner, a community health center, or a hospital outpatient clinic. Several demonstration projects currently are testing the viability of the healthcare home model for many Americans.

"The National Quality Forum (NQF) has completed significant work to advance care coordination, including the endorsement of a definition and framework for care coordination; the NQF-convened National Priorities Partnership; the designation of care coordination as one of six 'National Priorities' for national action; and the endorsement of preferred practices and performance measures for care coordination. Ultimately, achieving coordinated care will be possible only when healthcare entities collectively agree to place the patient at the center of care."

SETMA has now read all of these documents, resulting in a clearer understanding of the concept of care coordination, which has already helped us expand the plan of care and treatment plan our patients receive and has benefited others as some of these concepts where discussed in a medical-home leadership conference in which I participated on November 7. SETMA will also incorporate these new understandings into our care transition's audit.

SETMA is looking forward to our relationship with NQF. We think our patients, our practice and our community will benefit.

Re-Evaluating the Value of Members of the Healthcare Team
By James L. Holly, MD
Your Life Your Health
The Examiner
October 21, 2010

The ideal setting in which to deliver and to receive healthcare is one in which all healthcare providers value the participation by all other members of the healthcare-delivery team. In fact, that is the imperative of Medical Home. Without an active team with team consciousness and team collegiality, Medical Home is just a name which is imposed upon the current means of caring for the needs of others. And, as we have seen in the past, the lack of a team approach at every level and in every department of medicine creates inefficiency, increased cost, potential for errors and it actually eviscerates the potential strength of the healthcare system.

Why is this? Typically, it is because healthcare providers in one discipline are trained in isolation from healthcare providers of a different discipline. Or, they are in the same buildings and often are seeing the same patients but they rarely interact. Even their medical record documentation is often done in compartmentalized paper records, which are rarely reviewed by anyone but members of their own discipline. This is where the first benefit of technology can help resolve some of this dysfunction. Electronic health records (EHR), or electronic medical records (EMR) help because everyone uses a common data base which is being built by every other member of the team regardless of discipline. While the use of EMR is not universal in academic medical centers, the growth of its use will enable the design and function of records to be more interactive between the various schools of the academic center.

And, why is that important? Principally, because more and more healthcare professionals are discovering that while their training often isolates them from other healthcare professionals, the science of their disciplines is crying for integration and communication. For instance, there was a time when physicians rarely gave much attention to the dental care of their patients, unless they had the most egregious deterioration of teeth. Today, however, in a growing number of clinical situations, such as the care of diabetes, physicians are inquiring as to whether the patient is receiving routine dental care as evidence-based medicine is indicating that the control of disease and the well-being of patients with diabetes is improved by routine dental care. Also, as the science of medicine is proving that more and more heart disease may have an infectious component, or even causation, the avoidance of gingivitis and periodontal disease have become of concern to physicians as well as dentist.

Disruptive Innovation

In addition, Medical Home places major emphasis upon issues which historically have been the concern of nurses. Physicians who use EMRs are discovering that the contribution of nursing staff can make the difference in the excellent and efficient use of this documentation and healthcare-delivery method. No longer is the nurse a “medical-office assistant” ancillary to the care of patients, but the nurse is a healthcare colleague central and essential to the patient’s healthcare experience. As evidence-based medicine expands the scope of what *The Innovator’s Prescription: A Disruptive Solution for Health Care* By Clayton M. Christensen labels as

"empirical medicine" which ultimately leads to "precise medicine," it is possible for physicians and nurses to be a true-healthcare delivery team, as opposed to the nurses only being an aide to the physician.

Christensen identifies the following "Levels of medicine" and makes the following judgments about the future of healthcare delivery:

- Intuitive Medicine -- "when precise diagnoses isn't possible…where highly trained and expensive professionals solve medical problems through intuitive experimentation and pattern recognition."
- Empirical Medicine -- "As patterns become clearer, care evolves into the realm of evidence-based medicine…where data are amassed to show that certain ways of treating patients are, on average, better than others."
- Precise medicine -- "when diseases are diagnosed precisely…therapy that is predictably effective ...(can) be developed and standardized."

Change wrought by Precision Medicine

- "…(when) we know what type of bacterium, virus, or parasite causes one of these disease…"
- "…(when) we know the mechanism by which the infection propagates…"
- "…predictably effective therapies can be developed…"
- "…therapies that address the cause, not just the symptoms…"

As a result, Christensen concludes:

- "….nurses can now provide care for many infectious diseases…"
- "…patients with these diseases only rarely require hospitalizations."

It is easily recognized in this emerging paradigm that all of the schools in the academic healthcare center are actively involved in patient care and in the training of those who will be healthcare providers. Yet, it seems that the farther and farther a person advances in biomedical education, the obvious union of their disciplines at their foundations seems to be lost and the more isolated from the whole these "specialists" and 'experts" become. This even creates problems within the various disciplines as egocentrism isolates one medical specialty from another. It is as a result of the need for the integration of healthcare disciplines at the delivery level, that the imperative becomes obvious for the restructuring of the training of the members of this healthcare team. And, the first change must come in the relationships between the leaders of the training programs who educate and mentor future healthcare scientist, teachers, caregivers and researchers. The educational leaders must model this integration for their disparate student bodies and that modeling will require the investment of the most precious and rare resource: time.

Glue? Adhesion and Cohesion

What is the model for this restructuring of the relationships between schools in the academic healthcare centers? It has been suggested that there is "glue" which unites the members of the various schools in an academic healthcare center, which will ultimately create this team. I would argue with that. Glue is an adherent. "Adherence" is described and simultaneously defined by the following:

- "Two dissimilar parts touching each other but not fused."
- "The union of separate parts; tending to adhere to or be connected by contact."

If propinquity is the principle motivation for the forming of a team, it will not survive the stresses and pressures which tend to make the team fly apart.

On the other hand, "cohesion" is "the bonding together of members of an organization/unit in such a way as to sustain their will and commitment to each other, their unit, and the mission." Synonyms of "cohesion" are "harmony, agreement, rationality." Here is the source of the union of the various elements of the healthcare team in training. It is in the recognition of their commonness and in the acknowledgment of their being part of the same "organism."

Harmonics

The concept of "harmony" is valuable here also. Harmony is not the absence of discord; it is the presence of a common nature. The typical definition for a harmonic is "a sinusoidal component of a periodic wave or quantity having a frequency that is an integral multiple of the fundamental frequency." I smiled and chuckled aloud as I wrote this last sentence. It is a mouthful, but how is it related to our problem of healthcare delivery? If you have a room filled with tuning forks of different frequency and you strike one of the forks, all of the forks which are of the same frequency or a multiple of the same frequency, as the one struck, will begin to sound. Those which are intrinsically different will remain silent.

In a room of educators, some health science, some historians, some vocalists, some archeologists, etc., when the sounding is of excellent in healthcare delivery; when the sounding is of evidence-based medicine; when the sounding is of containing the cost of healthcare while maintaining the quality; when the sounding is of increasing the accessibility of healthcare by removing barriers of affordability, linguistics, literacy, etc; each member of the healthcare-education team, whether nurse, dentist, physician, scientist, physical therapist, laboratory technician or other, will begin to resonate, as they are all coherent, by their nature, to the process of sustained improvement in the delivery of healthcare.

It is as if the healthcare-education team, as the healthcare-delivery team, has become a symphonic orchestra made up of instruments which are different in sounding method but which harmonize to produce an aesthetically satisfying result. Remember, the Greek word "symphonia" means "sounding together." So it is that the members of the healthcare-education and the healthcare-delivery team "resonate together" to produce the results we all desire.

Personal Pilgrimage

My personal pilgrimage in this process began my first year in medical school, but it was not in the class room. One day, as I was leaving the medical school with a classmate, the Dean's secretary ran up to us and said, "Larry, you must go downstairs. There is a meeting for the new health careers program and the Dean is there by himself." Reluctantly, I went and began a two-year participation in the School of Medicine's Health Careers Program and a life-time of desire to help young people pursue health careers. Every Saturday, we brought high school students, principally Hispanics, to the school of medicine and introduced them to health careers. I realized then that the recruitment of a diverse student body to the various elements of the health science center was not going to be done en masse but it was going to be done one student at a time. As a result, one of the missions of the SETMA Foundation is to help underwrite the education costs for students who qualify but cannot afford health-career education.

The second element to my pilgrimage was in Clifton, Texas, after graduation from Medical School. With the birth of my second child days before graduation and with him in neonatal ICU, I had to work in order to provide for my family. Monday after graduating on Saturday, I left for Clifton. I lived in the hospital around the clock with two days off in a month to take the state medical boards. I learned the value of a healthcare team from an LVN when one night, as I was preparing to treat a patient in the ER, she said, "I have noticed that our doctors do that this way." She was so kind. She didn't say, "Hey, stupid, didn't you learn anything in medical school?"

Yet, over the next four weeks, my wealth of knowledge of physiology, pathophysiology, biochemistry, heart failure, etc., was augmented by a wealth of practical medicine taught to me by an LVN. What doctor cannot remember the same kind of experience with a nurse, or other healthcare team member who helped him/her through a patient encounter which was new? Why have we forgotten?

The third element of my pilgrimage was SETMA's migration to EMR. When SETMA was formed there was no uniformity in how medical records were created, filed or stored. Some dictated records, others hand wrote records. Some organized records alphabetically, others used a numeric system. On August 1, 1995, SETMA's medical-record-keeping illustrated all of the problems facing the future of healthcare in America. With the new millennium approaching, with all of the potential of 21st-Century technological care, SETMA was hamstrung by the use of mixture of a 19th –Century documentation system, i.e., pencil and paper, and a 20th-Century system, i.e., dictation and transcription. Neither system was capable of supporting innovation in healthcare delivery. In March of 1998, we purchased an EMR system.

Two events define our success with NextGen EMR and EPM. They occurred simultaneously. The first was our realization that this task was too hard and too expensive if all we were to get out of it was the ability to document a patient encounter electronically. It was this realization which pushed us past electronic patient records to electronic patient management. We realized that we had to develop the functionality for the EMR to enhance the quality of patient care, to increase the satisfaction of patients themselves and to expand the knowledge and skills of health care providers, if it was to be "worth it." It also had to expand the healthcare team to include all participants as active, valuable contributions to the delivery of healthcare. In the spring of 1999,

we made this transition to electronic patient management and the investment of time and money suddenly was "worth it."

The second event occurred in May, 1999, and it set the tone for the next ten years of EMR implementation. In a moment of frustration at the new system, which at this point of development was cumbersome to use and yielded little more than an acceptable record of a patient encounter, one partner said, "We haven't even begun to crawl yet," speaking of our use of the EMR. SETMA's CEO said, "You're right, but let me ask you a question. When your oldest son first turned over in bed, did you lament to your wife, 'this retarded, spastic child can't even walk, all he can do is turn over in bed,' or did you excitedly announce to your wife, 'he turned over in bed!'?" He smiled and the CEO added, "If in one year, all we're doing is what we are presently doing, then I'll join you in your complaint. For now, I am going to celebrate the fact that we have started and that we are doing more than before."

That celebratory attitude has given SETMA the energy and resolve to face hard times and the vision of electronic patient management has given us direction and substance to our goal. Today, we are not what we were, and we are not yet what we shall be, but we are on a pilgrimage to excellence which will never end. We started thirteen years ago at MGMA; where is the end? There isn't one and that is what helps us get up day after day, excited about the prospect of the future. Mostly what we celebrate today is the team which EMR has facilitated our forming.

Medical Home

Now, we come to Medical Home. As the healthcare education establishment is reorganizing itself to model the health-care-team concept for those they are teaching and mentoring, those in healthcare delivery are enjoying the opportunity to rethink our approach. Many of us have already experienced through the implantation the value of a healthcare team. Now with the power of the EMR, we have embedding HEDIS standards and other measures of quality into our EMR. We have designed a Coordination of Care review which allows us a snapshot at every visit as to where our patients are in their healthcare journey. We achieved NCQA recognition as a Tier 3 Patient-Centered Medical Home and AAAHC certification as a Medical Home. We have developed a Department of Care Coordination and staffed it with outstanding agents. Most of all, we have recognized how valuable the healthcare team is to our model of healthcare delivery and how central it is to Medical Home.

We value participants in healthcare delivery by what we pay them, but more essentially we value them by how we treat and relate to them. In the future, healthcare will undergo significant changes in monetary valuation of services which have been delivered. That will be forced upon us. However, our valuation of the contribution of others to our team is within our power to judge and acknowledge. How well and accurately we do that, to a great extent, will determine how we navigate the future toward fulfilling all of the potential of a patient-centered medical home.

A Review of 2010 and a Projection for 2011
By James L. Holly, MD
Your Life Your Health
The Examiner
December 30, 2010

One year ago tomorrow, our Your Life Your Health article summarized SETMA's expectations for the coming year. As we prepare to think about what we expect to accomplish in 2011, we will first look at our December 31, 2009 forecast of our expectations and see "how we did."

The SETMA Foundation

At the end of 2009, we said, "(this year), The SETMA Foundation matured into a significant force in the lives of our patients…We…experienced remarkable events in our patients' healthcare which would not have been possible without the resources of the Foundation." In 2010, the expanded role of the Foundation was supported by an additional $500,000 contribution by the partners and by our first significant contribution from outside of SETMA. Universal American, our principle HMO partner through Select Care of Texas and Texan Plus, gave a $150,000 gift to the foundation. We intended to have a fundraiser in 2010 but did not get that done. We will hopefully remedy that in the spring of 2011. We continued to see remarkable changes in people's lives due to the funds available through the Foundation. In addition, we saw the funds of the Foundation supplemented by the generosity of the gifts of time and talents from our non-SETMA colleagues in the Southeast Texas medical community.

Healthcare Policy

In "2009, SETMA…participated in the vigorous healthcare policy debate which has taken place in our country.": In 2010, SETMA began participating in plans for launching a new collaboration between health insurance, information technology and private medical practice to demonstrate that the best place for healthcare reformation – really transformation – is the private sector. At the end of 2011, we hope to be able to announce the successful launching of this plan in multiple locations around the nation. As we sat in planning meetings this past year, there was a growing and announced realization that all of the needs for change in the healthcare delivery system in America will be answered by the plans we are making. Ambitious? Absolutely. Impossible? Absolutely not! Unrealistic? Definitely, No! We look forward to being able to report progress and success in this arena.

In the past year, SETMA's story has been told all over America. Other practices continue to come to SETMA to learn about our approach to healthcare informatics and healthcare transformation. In early 2011, SETMA will receive a national award for improving healthcare delivery, the details of which are not able to be announced until January. In 2011, SETMA will participate in the first conference on the use of "systems thinking" produced by Dr. Peter Senge, professor at Massachusetts Institute of Technology (MIT) and author of *The Fifth Discipline*. Dr Senge's work and the ideas in his book have guided much of the development of SETMA.

Patient-Centered Medical Home

"In February of 2009, SETMA began exploring a new concept called 'Patient-Centered Medical Home.'" In April, 2010, SETMA submitted an application for recognition by NCQA as a medical home and in June, submitted an application for accreditation as a medical home by AAAHC. In July, SETMA received the highest recognition offered by NCQA, Tier III, and in August, we received accreditation by AAAHC for Ambulatory Care and Medical Home. With the creation of our new Care Coordination Department and the employment of the Director of Care Coordination, we continue to deepen our understanding of this aspect of medical home. In 2011, we expect to provide true care coordination with the result of coordinated care to all of our patients.

Joslin Diabetes Center

Additionally, SETMA received recognition for excellence in the care of diabetes from NCQA. In our December, 2010 report, it was stated, "In 2010, SETMA expects to complete the affiliation with Joslin Diabetes Center, which is an affiliate of Harvard University which has been in the planning stages for over two years. The uniqueness of this affiliation with a multi-specialty group has stretched the imaginations of everyone but is soon to be finalized. This affiliation will bring a new energy and dynamic to diabetes care in Southeast Texas."

In August, 2010, we formalized that affiliation. In September, representatives of SETMA attended the orientation and later the annual meeting of Joslin Affiliates in Boston. All of SETMA's providers completed a training program which includes study and testing, writing and presenting case studies on patients we have seen with diabetes (all identification was removed) and finally a four and a half hour discussion with Joslin endocrinologists and staff at SETMA. Now all of SETMA's primary care providers are designated as Certified Joslin Diabetes Center Providers. This is a first for Joslin and is a pattern which is hoped to be replicated all over America.

COGNOS Project

In our 2009 report, we stated: "SETMA chose the IBM Business Intelligence software package, *COGNOS*, with which to build the capacity to mine our electronic patient records (EMR) for the information needed to measure provider performance and with which to improve patient compliance." We have completed this project and are now routinely using COGNOS to examine our performance in regard to quality standards and the elimination of ethnic disparities of care and opportunities for improvement of our care of patients. In January, 2011, we will begin using our COGNOS Project to examine ways of eliminating preventable readmissions to the hospital.

Quality Metrics

"The generative power of SETMA's EMR has been captured as we have deployed every set of quality measures in existence," we reported in December, 2009. We discovered another which is Bridges to Excellence and in 2010, we deployed BTE multiple quality metrics. In 2010, SETMA also became a formal member of the National Quality Forum which endorses quality metrics

used by the entire healthcare community. SETMA representatives attended and participated as expert panelists at a NQF conference on “Care Transitions.”

It is noteworthy that SETMA was the only private medical practice in attendance at the NQF meeting. SETMA’s achievement n tracking, auditing, analyzing and public reporting of hundreds of quality metrics was acknowledged as remarkable. In 2011, SETMA will consolidate our work in this area and will make certain that this work is “making a difference in the care of our patients.”

In 2010, SETMA identified the concepts of “clusters” and “galaxies” of quality metrics. SETMA believes that single metrics will not change health care outcomes but that multiple metrics focusing on a single condition (clusters) and multiple clusters related to a single patient (galaxies) will improve a patient’s health.

Website Redesign

In 2010, SETMA completed the redesign of our website to include all of our electronic management tools, SETMA’s included material focused on our new **I-CARE** program, which is an expanded and improved support system for nursing homes, as well as collecting in one place the dozens of articles about SETMA (see **In-The-News**). In 2011, we will continue to work to make our website more useful for our patients and for our colleagues around the country who continue to express interest in replicating in their communities what SETMA has achieved in Southeast Texas.

SETMA has made much of our work more visible on our website including The SETMA Way, The SETMA Approach and the SETMA Model of Care. Another section entitled “**Letters**” displays important correspondence which we have had with others about healthcare policy and principles.

Our December, 2009, reporte stated, “Our website redesign includes a link to NextMD which is our EMR vendor, NextGen, secure and encrypted web portal for patient communication and education.” NextMD is now live and being used by our patients. In 2011, we will expand the use of this web portal for secure and confidential communication with all of our patients who use computers.

Public Reporting

In November, 2009, SETMA made a decision to publicly report by provider name our performance on over 200 quality metrics. We have fulfilled that commitment and are expanding the transparency of our work with our patients. Our concepts of “clusters” and “galaxies,” defined on our website have guided this development.

Technological Advances

Our 2010 reported stated:

- "In 2009, SETMA totally replaced our telephone systems with a new digital system which allows complex analysis of calling activity."
- "In 2009, we began placing printers in every examination room so that we could ensure that patients received education materials and evaluational materials such as the LESS Initiative, Disease Management plans of care and treatment plans and in the New Year, a comprehensive coordination-of-care review which will allow patients to know what care they need, what they have received and what remains to be done for them."
- In 2009, SETMA purchased the necessary computer software and hardware to redesign our network to improve the efficiency and increase the power of the server farm.

All of these advances are complete and continue to contribute to our progress, in the second year of their deployment.

Health Information Exchange

"In 2009, SETMA obtained licenses from NextGen not only for the previously mentioned web portal, *NextMD*[@], but also for *CHS*[@] (*Community Health Services*[@]). This NextGen product will allow non-SETMA providers and groups of provides to collaborate on sharing patient-care information, compliant with HIPPA and in a secure, encrypted environment. It will increase efficiency and decrease cost of referrals, communications and repeating of tests."

The HIE now connects SETMA and Baptist Hospital. On January 19, 2011, a community wide meeting will be held with all healthcare providers and organizations to invite them to join and to participate in the Southeast Texas Health Information Exchange. A letter was sent to them last week announcing the meeting. Sponsored initially by SETMA, this effort will be organized and managed by the community, making SETMA one of the first communities in the country to be so organized.

Dr. John Vardiman

Perhaps no person or event more reflects the nature and success of SETMA than the experience of Dr. John Vardiman. In spring, 2010, he finished his 23-year project of building his own schooner – just like the one in which Kevin Costner sailed away at the end of the movie, *Message in a Bottle*. At its launching his foot was crushed and had to be amputated above the ankle. SEMTA assured Dr. Vardiman that for at least one year his salary and benefits would continue whether or not he could work.

Six weeks later, he asked to make rounds on the weekend with the aid of his grandson pushing his wheelchair. Four months later, he asked to return to the clinic and to practice full time. A challenging set of evaluations and examinations were required and he fulfilled each one excellently. He is now back at work and amazing all of us.

His performance is a credit principally to himself but it is also an honor to SETMA and to the support and encouragement all providers and staff receive through life's crises.

2010

As we review, 2010, with the exception of the fund-raiser for the Foundation, SETMA achieved every goal we established for ourselves and more. It was an exhausting year but a successfully one. We could not be more pleased. These objective evidences of success do not address the subjective ones. The growing cohesiveness of SETMA's staff and the collegiality of all of our providers are remarkable testaments to our success. Only three and a half years since eight physicians left SETMA, we are stronger and more successful than ever.

Yet, we must defer the honor and praise witch we might receive to the goodness of God. The following is worthy of being repeated as it addresses the power and success of SETMA: This is taken from the inauguration ceremony of the Joslin Diabetes Center Affiliate at SETMA:

> "SETMA is a multicultural, multi-ethnic, multi-faith organization, which reflects the people we serve. At this solemn occasion, we cannot omit our acknowledgement of the source of our strength and success. It is, in our judgment, the providence and beneficence of Almighty God. As we sit and stand here, we are Jew, Muslim, Hindu, Buddhist, Christian and perhaps even atheist. Today we celebrate our common commitment to the good of our fellow man, whatever the fount from which that passion flows.
>
> "As we acknowledge God's goodness in human affairs, each of us will do so as we have been taught and as we believe. The exercise of faith by one does not insult nor impugn the faith of another. So, in our pluralistic society, I invite you to pray as you have been taught, as I shall pray as I have been. Whether in your tradition you pray with head bowed and eyes closed, or with eyes open and head elevated, I ask you to join me as I lead us in thanking God for His goodness to us all."
>
> **Prayer**
>
> "Heavenly Father, in the Name of the Lord Jesus Christ, We thank You for Your goodness to us. We thank You for the life and legacy of Elliott P. Joslin. We thank you for allowing SETMA to be part of an enterprise that brings good to those whom You love and care for. We thank you for our colleagues in the healthcare profession and particularly at the Joslin Diabetes Center.
>
> "We pray for the wisdom and knowledge to give the best care there is to those who deserve nothing less. It is our hope that if we should gather here again in fifty years, we would be able to celebrate improvements in the care of those with diabetes which would be as a noteworthy as the changes for which Elliott P. Joslin and his Center were responsibility in his long and illustrious career. In Christ's Name, Amen."

2011

What is before us in 2011? Some of it has been addressed above. SETMA shall:

1. Expand the use of NextMD
2. Expand the HIE to the entire healthcare community which desires to participate.
3. Expand our use of COGNOS.
4. Recertify with AAAHC.
5. Apply for and receive Meaningful Use certification by CMS.
6. Complete plans for "5010" a new billing program mandated by CMS.
7. Complete plans for fulfilling "ICD-10" and SNOMED.
8. Respond to increasing numbers of physicians who wish to join SETMA. We welcome all who wish to participate collaboratively for the success of our patients and community.
9. Continue our advances in quality care.
10. Continue to transform the delivery of healthcare and to support others who wish to do the same.

In December, 2011, we shall see how we have done.

Concierge Medicine and the Future of Healthcare
By James L. Holly, MD
Your Life Your Health
The Examiner
January 27, 2011

Recently, I received an e-mail from a friend. His wife's physician is changing his practice to a plan where she would pay him $1,500 a year in addition to insurance payments. The physician will limit his practice to only 600 patients and will give her his cell phone number for instant, round-the-clock, access. My friend's question was, "Should she do this?" I sent him by cell phone number and told him to send me $1,500.

I already knew the answer I would give but because my friend was the valedictorian of our high school class and one of the smartest people I know, I wanted to give him a substantive answer. I Goggled "concierge medicine" and got an education.

MDVIP, *MD*^{2}, *Signature*, *Excel MD*, *PinnacleCar*e, *ABC (Above and Beyond), Concierge Choice Physicians* – are only a few of the names associated with the "concierge" movement. My searched resulted in over 150,000 references. One website, announcing a conference on this form of medicine, states:

> "'Concierge medicine,' now known as direct medicine, is emerging as the only solution for physicians to escape the failing health care system. Over 1,000,000 patients across the country are in a direct practice and according to the Physicians Foundation study 17,000 primary care doctors intend to transition to a direct practice in the next 5 years. Direct practice is a way to get back to practicing medicine without all of the interference of insurance companies and other third parties. Physicians simply can no longer increase volume and push patients through an assembly line to survive, and yet practice quality care, while enjoying being a physician healer."

This ad, like others, included motivations like "fear of the future of medicine," "promised increase in income: "control of your future", "escape from intrusive governmental regulation" and more. Interestingly, the better websites promised:

- Same day appointments
- Longer appointments
- Screening care
- Preventive care
- Personalized wellness plan
- After-hours access
- Attention from your personal physicians
- The provider's personal cell phone number

Many of these benefits sounded strangely familiar, as they are similar to some of the principles of patient-centered medical home (PC-MH), only PC-MH does not require the payment of a significant "franchise fee" to the provider. While the movement also touts the restoration of the physician/patient relationship – not unlike PC-MH – they fail to mention that some of these franchises are owned by corporations with non-physician stock holders who expect to profit from their investment. The plans also promise that the routine care of the patient will continue to be paid by their insurance company. This latter proposition is not certain.

CMS and Concierge Medicine

In a 2004 study mandated by the government, the General Accounting Office argued that "concierge medicine" did not limit access to care because only a few physicians (1233 at the time as opposed to tens of thousands today) were involved. The study concluded that as long as the model did not duplicate charges for services CMS paid for, there is no problem with continuing to be a CMS provider while charging a "membership fee" for a practice. As the movement grows and as they continue to tout that if you join their "concierge practice," you will receive preventive healthcare, which, of course, you should have been receiving already, it appears on the surface that this model is duplicating charges for services already paid for by CMS. The GAO study notwithstanding, every physician who moves to the new form of practice, functionally removes one provider from the pool available to the general population. And, each provider also dismisses 80+% of patients from the practice. It will be argued here that physicians have the right to make this choice for themselves. However, as the country grapples with healthcare access, this model should not be promoted by our finest healthcare institutions in the land.

State Medical Societies and Concierge Medicine

The Texas Medical Board (TMB) has not taken a position on "concierge medicine" at this time but I suspect will have to as the popularity of the model grows. Proctor & Gamble's "take over" of MDVIP is the subject of the first article on the TMB's list of articles. It notes that P&G expects to net $300,000 a year from each of its practices participating in MDVIP. An indirect cost of $25,000 a month cost added to the overhead of a primary care practice is not an inconsequential sum for non-medical support. If that fee is calculated on membership and/or productivity, it may be found to violate the TMB's requirement for physicians only to own medical practices.

Hospital Staff Privileges and Concierge Medicine

If the "concierge" physician is going to follow his/her patients in the hospital, then he/she will have to have hospital privileges. This means that he/she will have to "take call" for unassigned. and/or uninsured patients, who present to the emergency department for care and which require admission to the hospital. If the physician refuses to follow the patient after discharge from the hospital, he/she will have to say to his/her colleagues, "I want you to assume my community health responsibility and follow-up this patient in your

clinic, as my patients cannot be bothered with this type of patient and I will not be bothered by them either." If that is not a violation of the patient-care oath every physician embraces; it should be. If being a physician is simply a way to "make a living," and a very good one at that, "concierge medicine" which identifies the physician exclusively as an entrepreneur, is acceptable; if being a physician is a "calling," which makes it a "profession,' then it "concierge medicine" is not acceptable.

Ethical Issues

Whether there are ethical issues with "concierge medicine" remains to be concluded. The answer may depend upon the community in which physicians were trained. In Texas, where public support is the principal method of support of medical education, there is no legal but there is, in my judgment, a moral obligation for physicians to "give back" to the community that gave them the right to practice medicine. This does not make the physician an indentured servant but it does mean the physician has a responsibility to patients other than those who can pay a franchise fee for care.

At a time when the principle issues of public discourse in healthcare delivery is access to care and the cost of care, it seems that physicians who do have a societal responsibility to their profession, should be looking for ways to effectively and excellently expand the scope of their care rather than to take the "cream of the crop" and leave 80% of their former patients to fend for themselves. This responsibility should have physicians working to design methodologies for providing excellent care to the most vulnerable of our neighbors rather than cutting them off from care.

Entrepreneurism versus Professionalism

"Concierge medicine" may be the ultimate expression of entrepreneurism in medicine as opposed to professionalism. In this column's April 15th and April 22, 2010 articles, we discussed "Entrepreneurism versus Professionalism." Those articles can be reviewed at www.jameslhollymd.com under Your Life Your Health. The concept of "concierge medicine" was not addressed there, but it is at the heart and soul of the issue as is clearly indicated by the interest of corporation to have a stake in this form of medicine.

Many of us who argue that basic healthcare, which includes timely access to a healthcare provider, diagnostic and preventive care, are the right of every citizen. Professionalism in healthcare is at its best supportive of that access to care. That care should be available regardless of the patient's economic status, or even their insurance status.

It is one thing for a physician not to accept responsibility for a patient's care for a variety of reasons. It is another for a physician to withdraw that acceptance for an economic reason. Many of us were surprised when the Mayo Clinic in Arizona announced that all patients with Medicare insurance for whom Mayo had cared for for years would now have to find new healthcare providers. The problem was the reimbursement rates of Medicare did not fit the Arizona May's economic model.

Having studied the life and history of the Mayo brothers who founded the Mayo Clinic, I wonder how they would respond to this act of raw entrepreneurism. I wonder how they would feel about the Mayo Clinic allowing a "concierge business," owned by Proctor & Gamble to use the Mayo name in encouraging patients to "buy into" the "concierge" model of care. And, the website of MDVIP does not claim the right to refer patients to Mayo, but claims an "affiliation" with Mayo.

The ultimate ethical crisis for the "concierge" model of care comes after a patient is accepted into the practice and then becomes unable to pay the "franchise fee." Will the patient be dismissed from the practice? If so, then this is a serous ethical dilemma. If the only bond between a patient and their physician is a franchise fee, we have really come a long and bad way, in healthcare. If the "concierge practice" will not dismiss a patient who can no longer or who chooses to no longer pay the franchise fee, how many will be so accommodated? Will one, five, ten, fifty, be kept on as patients or will all be immediately dismissed from the practice?

Medical Home and Concierge Medicine

There are similarities between the vocabulary of patient-centered medical home and "concierge medicine." But their differences overshadow the vocabulary. The following table contrasts some of those differences:

	Medical Home	**Concierge Medicine**
Method	Transforming the practice to benefit all patients.	Artificially limiting the size of the practice to benefit the few.
Goal (Unique to the Model of care)	Collaborating with the patient to produce coordinated care	Improving patient convenience
Public Policy	Increasing access to care for all patients	Significantly deceasing access to care for 80% of patients
	Deceasing cost of care	Increasing patient cost of care
	Eliminating Ethnic Disparities in care	Probably eliminating ethnic diversity in the practice
Dismissal from practice	No structural reason	Non-payment of franchise fee presumably
Treatment content	Evidenced-based medicine	Evidenced-based medicine
Record System	EHR with electronic patient management tools	EHR unclear how extensive
Transitions of Care	Plan of Care and Treatment Plan with care coordination	Undetermined

Barriers to Care	Evaluated and addressed	Presumably none exist due to patient selection on economic basis
Standards of Care	Published Quality Metrics	Undetermined
Endorsements available	Quality by NCQA, AAAHC, etc	Corporate by claimed affiliation with Mayo, Cleveland Clinic and others

Summary

Some have justified allowing their name to be associated with "concierge medicine" because they provide educational materials to any physician. There is nothing in this critique which argues that physicians do not have the right to do "concierge medicine." The argument is whether they ought to do so, or not. Similarly, there is nothing to prevent a prestigious organization from providing educational materials to a "concierge medicine" company. However, that does not require an organization to allow their name being used to endorse the concept of "concierge medicine." And, however it may be explained by the nationally-known organizations, "concierge medicine" claims that they are "affiliated" with these organizations.

The Centers for Medicare and Medicaid (CMS) goes to great lengths to make certain that those who care for their beneficiaries are providing them quality care. That effort will expand. The "concierge medicine" movement exists because of the movement's rejection of "government control," "government intrusion" and their assessment of the "impending collapse" of healthcare in the United States. Yet, they still rely upon pubic support of their practices by making sure their patients are insured often by Medicare but apparently never by Medicaid. And, if their patients need attention at one of their prestigious affiliates, they are clear that the patent is responsible for all costs including travel and lodging to visit one of their affiliates. However, the "concierge practice" will make a phone call or two for the patient.

Pilgrimage to a Patient-Centered Medical Home
by Carrie Vaughan
Your Life Your Health
The Examiner
February 17, 2011

(Editor's Note: This article appeared in *The Doctor's Office*, which is a web based publication of *HealthLeader's Media*. It was compiled from an Interview with Dr. Holly. It is presented in a question-and-answer format.)

For the past two years, Southeast Texas Medical Associates (SETMA) has been on a journey to be recognized as a patient-centered medical home (PCMH)—although, in truth, the journey began more than a decade ago.

The Beaumont, TX–based multispecialty practice began aggressively working with managed care in 1997, says CEO **James L. Holly, MD.** "This was an effective way to address many of the needs of our patients, especially the cost, quality, and access to care by our medically most vulnerable friends and neighbors." SETMA then became involved in Medicare Advantage, which enabled the practice to extend care to many patients who previously could not afford or obtain it.

In 1998, SETMA adopted electronic health records, but soon realized that they were too expensive and difficult to manage if the only benefit was an electronic method of documenting a patient encounter. So the following year, SETMA redirected its efforts to electronic-patient-management and began developing disease and data management tools.

In 2000, SETMA determined that to provide excellent care, it needed to track the quality of care, audit the care given to populations of patients, and statistically analyze its outcomes. "We began tracking and auditing various quality metrics, including diabetes, hypertension, care transitions, congestive heart failure [CHF], and chronic stable angina— most of which were published by Physician Consortium for Performance Improvement. In time, we expanded that to include other nation- ally recognized metrics," says Holly. Finally in 2009, SETMA embarked on its journey to be recognized as a PCMH.

Recently, Holly discussed with *HealthLeaders* his views on SETMA's care model, healthcare reform, and the lessons learned along the way:

HealthLeaders: What were driving forces behind your decision to adopt a PCMH model of care?

Holly: The features of medical home which intrigued, attracted, and challenged us were:

- The process of coordination of care and the outcome of coordinated care.

- The further development of our team approach to healthcare, including a truly collegial relationship between nurses, medical assistants, administration, information technology, nurse practitioners, and physicians.
- The realization that the "patient-centered"element of medical home was the ultimate reality of the principle we have stated to our patients for the past fifteen years.
- We have long given our patients report cards telling them what they should expect from their healthcare provider. Now, we have added outcomes transparency to those expectations with our decision to publicly report process and outcomes metrics.
- Our COGNOS Project (using business intelligence software to build a data mart and auditing tools) enables us to do real-time auditing on our care processes and outcomes.
- Believing the key to 21st century healthcare is thinking about our patients when they're not in our presence and using technology to fulfill the requirements of excellent care.

This process led us to seek medical home recognition from the National Committee for Quality Assurance [NCQA] and accreditation from the Accreditation Association for Ambulatory Healthcare [AAAHC], the two bodies offering evaluation of medical groups as medical homes.

HL: How does your model of care work?

Holly: At the core of SETMA's practice is that one or two quality metrics will have little impact upon the outcomes of healthcare delivery. SETMA employs two definitions: A "cluster" is seven or more quality metrics for a single condition (i.e., diabetes or hypertension), and a "galaxy" is multiple clusters for the same patient (i.e., diabetes, hypertension, lip- ids, and CHF). SETMA believes that fulfilling clusters and galaxies of metrics at the point of care will change outcomes.

The following are the key elements of our model of care:

- The **tracking** by each provider on each patient of their performance on preventive, screening, and quality standards for acute and chronic care. Tracking occurs simultaneously with the performing of these services by the entire health- care team, including the provider, nurse, and clerk.
- The **auditing** of performance on the same standards either of the entire practice, each individual clinic, and each provider on a population or panel of patients.
- The **statistical analyzing** of the above audit performance to measure improvement by practice, by clinic, or by provider. This includes analysis for ethnic disparities, and other discriminators such as age, gender, socioeconomic groupings, education, and frequency of visit.
- The **public reporting** of performance on hundreds of quality measures by provider. This places pressure on all providers to improve, and it allows patients to know what is expected of them. The disease-management-tool plans and medical-home-coordination document summarizes a patient's state of care and encourages them to ask their provider for any preventive care that has not been provided. We believe this is the best way to overcome provider and patient treatment inertia.

- The design of **Quality Assessment and Permanence Improvement initiatives**. This year, SETMA's initiatives involve the elimination of all ethnic diversities of care in diabetes, hypertension, and dyslipidemia. Also, we have designed a program for reducing preventable readmissions to the hospital.

HL: How easy was it to transition to this model of care?

Holly: It is one of the most difficult things we have done. I use the word "is" because I believe that all of us who already have medical home recognition or accreditation or both are still in the process of transforming the practice of medicine by the principles, ideals, and goals of medical home. The formal process took SETMA from February 16, 2009, to the date we first submitted our NCQA application on April 12, 2010.

The transition is a true transformation rather than a reformation. Reformation comes from pressure from the outside, while transformation comes from an essential change of motivation and dynamic from the inside. Anything can be reformed if enough pressure is brought to bear. Unfortunately, reshaping under pressure can permanently alter the structural integrity of that which is being reformed. Also, once the external pressure is eliminated, the object often returns to its previous shape as nothing has fundamentally changed in its nature. Transformation is not dependent upon external pressure, but is sustained by an internal drive, which is energized by the evolving nature of the organization.

The currently proposed reformation of the healthcare system does nothing to address the fact that the structure of our healthcare system is built upon a patient coming to a healthcare provider who is expected to do something for the patient. There is little personal responsibility on the part of the patient for their own healthcare, whether as to content, cost, or appropriateness.

Transformation of healthcare would result in a radical change in the patient-provider relationship. The patient would no longer be a passive recipient of care. The collaboration between the patient and the provider would be based on the rational accessing of care based on need, not desire.

HL: How is the patient experience different today under this model?

Holly: The patient experience has dramatically changed. For instance, the patient's care is evaluated on the basis of more than 200 quality metrics; the patient receives a summary of these quality metrics with a recommendation to contact his or her healthcare provider to request that any metrics not completed be done and care transition points are attended to; and a "plan of care" and "treatment plan" baton is handed off to the patient so that they can participate effectively as the head of their healthcare team.

Because of SETMA's department of care coordination, every patient who leaves the hospital receives a follow-up call the day after discharge. This is not a 15-second administrative call to fulfill a metric, but it is a 12–30 minute call, which has substance. Selected patients seen in the clinic receive follow-up calls at any interval determined by the healthcare provider related to vulnerabilities or complexities of their care.

In addition, both during the visit and in the treatment plan, a section is included which is entitled, "What If?" This section shows the patient how his or her risk will change if a number of individual elements or a combination of multiple elements used to calculate the risk is changed.

HL: What steps did you take to ensure your providers and support staff were on board?

Holly: The first step we took in transforming our practice was an in-depth evaluation of our practice by the medical home standards published by CMS and NCQA. All of our executive management staff and providers were involved in this evaluation, which resulted in a 400-page review of our practice. The evaluation allowed all of our providers to see where we were, where we needed to go, and be part of the transformative process.

We looked at the requirements for medical home and designed tools that made it easier to fulfill the requirements than not to fulfill them. We were able to transform our disease management tool follow-up documents into plans of care and treatment plans.

We close the clinic one-half day each month and have a seminar to discuss the ideal of medical home and how we are performing or not performing. We have illustrations of where we are doing it well, and we share that by e-mail daily; and when we do not do it well, we share that as well.

We welcome and seek ideas from all members of our team to improve our processes and outcomes. We post on our website by provider name performance on more than 200 quality metrics.

HL: What advice do you have for practices seeking to undergo a similar transition?

Holly: Look into your own organization for the creativity and energy to change. There are many consultants and agencies who would like to charge you hundreds of thousands of dollars to transform you. At best that will be reformation. Transformation can only come from within, and it can only be sustained by your own passion, resolve, and relentless pursuit of excellence. Get counsel from those who have succeeded, evaluate their ideas, and modify them to your situation. Often the best help is free. Excellence and expensive are not synonyms.

HL: For practices seeking recognition as a medical home, what should they know about the application process?

Holly: It is tedious and complex, particularly NCQA. But that may just reflect my prejudice about forms; others may find them simple and straightforward. Currently, less than 1% of medical practices have any form of medical home recognition, so the process is in its infancy. It is SETMA's judgment that an ideal process would be a combination of AAAHC and NCQA.

HL: What lessons have you learned along this journey?

Holly: It is worth the process, the price, and the pain. This is the future of healthcare, and it is possible to be part of that future now. It is not easy, but it is not impossible. Measure your success by your own advancement and not by whether someone else is ahead or behind you. In the same way, share your success with others.

The following steps will help:

- Determine where you are and where you want to be.
- Select the template or model you will follow.
- Outline the steps you will take.
- Develop a timeline for completing each task.
- Be innovative. Emulate the best of others, but expand upon their work and make it yours
- Be patient but eager
- Enjoy what you are doing and celebrate where you are.

Patient-Centered Medical Home
Care Coordination and Coordinated Care
By James L. Holly, MD
Your Life Your Health
The Examiner
January 20, 2011

Perhaps the most complicated and in some ways confusing element of Patient-Centered Medical Home[R] (Registered Trademark of NCQA, PC-MH)) is the concept of "care coordination." In order to produce ***coordinated care*** (an outcome of care), it is important to define and describe ***care coordination*** (a process of care). The following two definitions of "***coordination***" are drawn from a medical dictionary and from a general dictionary:

- "the harmonious functioning of parts (as muscle and nerves) for most effective function."
- "the act of coordinating, making different people or things work together for a goal or effect; the resulting state of working together; cooperation; synchronization; the ability to coordinate one's senses and physical movements in order to act skillfully."

As we explore medical home, we discover that the use of these words as ***jargon,*** which is defined as:

> "The language used by people who work in a particular area or who have a common interest. Much like slang, it can develop as a kind of short-hand, to express ideas that are frequently discussed between members of a group, though it can also be developed deliberately using chosen terms. A standard term may be given a more precise or unique usage among practitioners of a field. In many cases this causes a barrier to communication with those not familiar with the language of the field."

In regard to medical home, "***coordinated"*** and "***coordination***" are used to mean more than they do in general medical or in general popular usage, therefore they are ***jargon,*** and to be understood they must be described. Without this description, which is different from a definition, we will not understand what "***coordinated care"*** is. We will not know what we are trying to achieve and we will not know if we have achieved it, if we should.

The History of Care Coordination

The more we understand about Care Coordination, the more it is apparent that in medicine, care has always been coordinated. The questions are, "How effectively has it been done?" and if it has not been done effectively, "How must it be done to be effective?" Traditionally, Care Coordination has consisted of three statements. The healthcare provider tells the patient:

1. "I have called your medicines to your pharmacy," or "Here are your prescriptions."
2. "Please make an appointment for ten days."
3. If you get worse, call me.

This was essentially the total content of the provider's "plan of care" and "treatment plan," which are the elements of care coordination. Their inadequacy is obvious. In this analysis of care coordination at the time of a patient's visit to the healthcare provider, we can identify at least seven deficiencies.

Deficiency One: Structural.

To be adequate, the "plan of care" and "treatment plan" must be written down; it must be personalized, not only with the patient's name, but with the patient's medical data. It must be given to the patient at the point of care and it must be complete.

Other than prescriptions, nothing is written down in the traditional care coordination, at least anything which is given to the patient. Even the prescriptions are not written for the patient. The intent of PC-MH requires that the "plan of care" and "treatment plan" be written and it must contain not only the treatment instructions but also:

1. The diagnostic assessment.
2. The goals of therapy.
3. The patient's risk stratification
4. An assessment of where the patient is in progress toward the goal.
5. How the patient can and should care for himself.
6. What complications the patient should be alert for and what to do if one or more occurs.
7. Time, date, place and provider with whom the follow-up appointment is scheduled.
8. Results and interpretation of the most recent laboratory values and/or other tests.

Key Point: Generic information given to the patient, which is not personalized and/or which does not contain the patient's personal health information will usually be ignored. But, when the patient is given educational materials or instructions with their name on it and with their data in it, they will pour over it. This is why the structure of "care coordination" requires that the information given to a patient have the patient's name on it and that it includes the patient's personal information. One of the most teachable moments in medicine occurs when the patient returns to a follow-up visit, and with the previously given "plan of care' and "treatment plan" in hand, declares, "This information is wrong!" At this point, the patient is engaged and ready to learn.

Deficiency Two: Functional

There are 8,760 hours in the year. If a patient receives significant healthcare in a given year, he/she may be in the healthcare provider's office twelve times, Even if the visits are sixty-minute, extended visits, and they seldom are, the patient is still "in charge' of their own health for 8,748 hours that year.

For the patient's healthcare team to "win" the "race to health," the dominant member of that team – the one in charge of the patient's care for the overwhelming majority of time, which is the patent -- must be equipped to assume responsibility for their own care. Even if it is argued by

the provider that, "I told all of that to the patient," we are all aware of the recall anyone has of complex, unfamiliar matters, when the only "teaching and learning method" is auditory.

Key Point: The more important information is, the more probable it is that a person will forget that information, remember it incompletely, or be confused by it. This is particularly the case when the information is complex, containing unfamiliar terms and spoken to the patient only once and briefly.

It is at this "transitions of care" – when the patient leaves the point of care, which most often is the healthcare provider's office-- where "care coordination" is most critical. As a result, a poster now appears in all of SETMA's examination rooms and in strategic points around the clinic. It is called "The Baton," and it illustrates the necessity for the healthcare provider to "hand off" "the baton" to the next member of the team – the patient -- who is to carry the team's plans and purposes to the goal – improved or sustained health.

The following appears on the "Baton" poster:

Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

"The baton" is a metaphor for the "plan of care' and a "treatment plan" which informs and empowers the patient to assume responsibility for his/her own care. In this context, the term "grasp" is apt, as the word refers both to physical and mental acts. The patient must not only receive "the baton' in the hand physically (grasp it), but must also comprehend the content of the "baton" mentally – "lay hold of it with the mind." If the patient "grasps" – understands, comprehends -- the "plan of care" and the "treatment plan," i.e., "the baton," and if the patient accepts – agrees to it and determines to carry it out -- the "**patient/provider complex**" is formed, completing the team and maximizing the opportunity for the team's success.

Key Point: The patient/provider complex" is the essential element of success for effective healthcare action to be taken; particularly in the ambulatory setting. Without the formation of this element, at best the process will be incomplete and the outcome will only be partially successful.

Deficiency Three: Cultural
In a simpler time, everyone spoke the same language, or received care within their own community, where everyone had similar mores, values and even similar religious beliefs. The three-sentence "plan of care" with which we started this discussion makes certain assumptions, which may or may not be true. Most healthcare providers in the United States speak a single language and often the prejudice is, "If you don't speak my language, learn it." The standards of PC-MH, however, require that the provider assume responsibility for making certain that the patient "grasps" – comprehends and understands and is able to carry out -- the "plan of care" both from a linguistic and a literacy standpoint.

PC-MH does not require that the provider speak multiple languages but that he/she is aware that the patient's primary or only language is different from English, and/or that the patient cannot read written instructions, or comprehend spoken ones. Later, we will discuss the Department of Care Coordination to which such needs should be referred.

Key Point: When the cultural issue is literacy, it is more important to increase the patient's knowledge than it is to attempt to provide care with the knowledge they already for. Respect for the important of our patient's to the provider/patient complex requires that we believe, that in most instances, the patient is able to learn everything they need to know in order to participate effectively in their own care. However, that learning will only result when the patient is given the information in a language they understand and in a format they comprehend.

Deficiency Four: Social

As the family structure in our society has deteriorated, more and more of the task which once were fulfilled by the family unit is now being assumed by the society which most often means the government. Whether this is right or wrong is not the intent of this discussion. The intent is for the provider to recognize that no matter how accurate his/her diagnosis, no matter how excellent his/her "plan of care" and "treatment plan" is, if the patient is unable to access or acquire that care, the best care available anywhere has done the patient no good.

It is imperative for the provider to know whether the patient lives alone and/or has a social structure for support in obtaining healthcare and for carrying out the "plan of care" and "treatment plan." One of the most valuable ICD-9 codes – the system whereby providers document the patient's diagnosis -- in a geriatric practice is described as, "Social – Lives Alone." Many "transition of care" issues are seriously impacted by this one piece of information. Both the cost of care and the effectiveness of care will be affected by not knowing this one thing.

When trying to control the blood pressure or blood sugar of an elderly lady, it is impossible unless you know that a grandson, who is on drugs, lives with the patient and adds enormous stress to the patient's "golden years." Whether a person lives in social isolation, or in a nurturing social environment is critical to the plan of care and treatment plan.

Key Point: The involvement of social agencies, home care agencies and/or protective services is important to the care of vulnerable populations whether young or old. Attempting to coordinate care without social information is impossible.

Deficiency Five: Financial

The "plan of care" and "treatment plan" must include documentation as to whether or not the patient has financial barriers to their carrying out the plan. If a patient cannot purchase medications, the prescriptions will do them no good. If a patient attempts to "stretch" their medications to make them last until their next pay check by taking a reduced dose, or decreasing the frequency of medication, the prescription does them no good.

Care Coordination will not only include an assessment of financial barriers to care but will also include an attempt to help the patient obtain the care they require. This may be done by social agencies, pharmaceutical-assistance programs, or it may be done by the medical practice forming a Foundation through which resources can be obtained. Whatever the method, and there will probably be multiple ones, the medical home will help the patient obtain their care if they are unable to do it for themselves.

Key Point: The assessment of the patient's ability to obtain care is as important as an accurate diagnosis and treatment.

Deficiency Six: Integration of Care

The simple "plan of care" and "treatment plan" which was traditional did nothing to determine what other care the patent needed. A thorough plan of care must take into account other care required by the patient and whether the patient has the transportation and ability to receive that care. It must also account for whether the care given at point A could or does interfere with or interact with the care the patient will receive at pint B. Integration of care means that laboratory results required by multiple providers will be available either through a health information exchange, or through someone taking responsibility for making that information available to all providers. What cannot happen is that the patient is given multiple appointments at the same time, or in a time-frame where one appointment overlaps with another.

The patient's convenience should be considered, particularly when they live at some distance from the point-of-care. For instance, this writer attended an appointment with a friend at a world-famous facility. The travel time was significant and the family wanted the patient, who was ill and ill-equipped to travel frequently, to return four days in a row for four different appointments. Appeal was made and when the appeal was resisted, pressure was applied to do all appointments in that one trip. When the accommodation was made, it was shocking that the duration of three of the appointments were 90 seconds for one, 55 seconds for the second and three minutes for the third. The facility wanted the patient to travel a total of twelve hours for visits lasting a total of 325 seconds.

Key Point: The patient's convenience is not the most important consideration but it is not to be ignored either. Often, when a complicated treatment plan is prescribed, the patient will not complain but will decide what he/she will do and what he/she will not do. We can improve compliance by integrating care.

Deficiency Seven: Preventive and Screening Care

Our traditional three-part plan of care and treatment plan also is deficient in that it does not overtly address the patient's preventive health and disease screening needs. At a time when the healthcare debate is about extending excellent healthcare to all Americans, a movement has arisen and is being embraced by many where only the wealthy are promised excellent care. This movement is called "concierge" medicine. Patient's pay the doctor an annual fee which ranges between $1,500 and $3,000, for which the patient is guaranteed same-day-access to their provider, preventive health care and screening health test and a personalized wellness assessment

and plan. All of these are a part of a medical-home treatment plan. At every visit to the medical home, the patient's preventive health status and their screening health needs should be assessed and should be reported to the patient in their "baton," their plan of care and treatment plan. This should be done without extra cost to the patient such as that required by the "concierge" practice model.

Summary

These are the elements of the process of care coordination and when fulfilled, they should result in coordinated care. The outcomes of care should be improved and excellent care should be the result of all who are part of a Patient-Centered Medical Home.

Reducing Preventable Readmissions to the Hospital
By James L. Holly, MD
Your Life Your Health
The Examiner
March 31, 2011

It is one thing to determine to do something to improve patient safety, to achieve cost savings, or to improve treatment outcomes in healthcare. It is another to do it. Over the past thirteen years, SETMA has identified the following principles about choosing a new quality initiative; they are:

1. Begin a new project while completing another
2. Build upon your past work
3. Leverage your resources in improving care
4. Think about what you want to accomplish
5. Examine your past work and ask if it has made a difference
6. Develop an algorithm to electronically audit to transform data to information
7. Use the information to implement change that will make a difference

This description of our current hospital readmission initiative illustrates these principles. Before looking at our initiative to reduce preventable readmissions to the hospital, look at the Institute of Medicine's report (***REDESIGNING CONTINUING EDUCATION HEALTH PROFESSIONS, Institute of Medicine of National Academies*** (IOM) December 2009) which recommends remodeling "continual medication education (CME)" to "continuing professional development (CPD)."

Remarkably, we will discover that CPD is not a great deal different from "continual quality improvement (CQI)" in a medical practice. The IOM's report quotes Goethe on its title page; he said, "*Knowing is not enough; we must apply. Willing is not enough; we must do*." Here is the difference between CME and CPD. The former is about taking in information; the latter is about transforming performance. The former will not necessarily produce the latter but the latter will begin with questions and answers. This is not unlike the old mantra, we all learned in our medical training, "See one; do one; teach one." It is when you can teach others that you have truly learned if the basis of your teaching is that you have "done."

The IOM report states:

> "In recent years, a broader concept, called continuing professional development (CPD), has been emerging that 1ncorporates CE as one modality while adding other important features. CPD is learner-driven, allowing learning to be tailored to individual needs. CPD uses a broader variety of learning methods and builds on a broader set of theories than CE. CPD methods include self-directed learning and organizational and systems factors; and it focuses on both clinical content and other practice-related content, such as communications and business." (p. 17, emphasis added).

The IOM's report went on to say, ""…knowledge of any clinical skill can be broken down into four progressive stages." They are:

- "Declarative knowledge: the learner gains the awareness to identify a problem or to know what should be done;
- "Procedural knowledge: the learner not only understands that there is a problem to solve but also gains knowledge of how to go about solving it;
- "Competence: the learner advances to a stage where he can demonstrate or show how a problem is to be solved; and
- "Performance: the learner identifies the problem, knows how to address it, demonstrates the needed skill, and solves the problem in practice—the learner does what he has learned." (pp. 95-96)

The "doing" which will result from "CPD" is described by the IOM's report as follows: "…an effective CPD system should ensure that health professionals are prepared to:

- 1. "Provide patient-centered care.
- 2. "Work in inter-professional teams.
- 3. "Employ evidence-based practice.
- 4. "Apply quality improvement.
- 5. "Use health informatics." (p. 94)

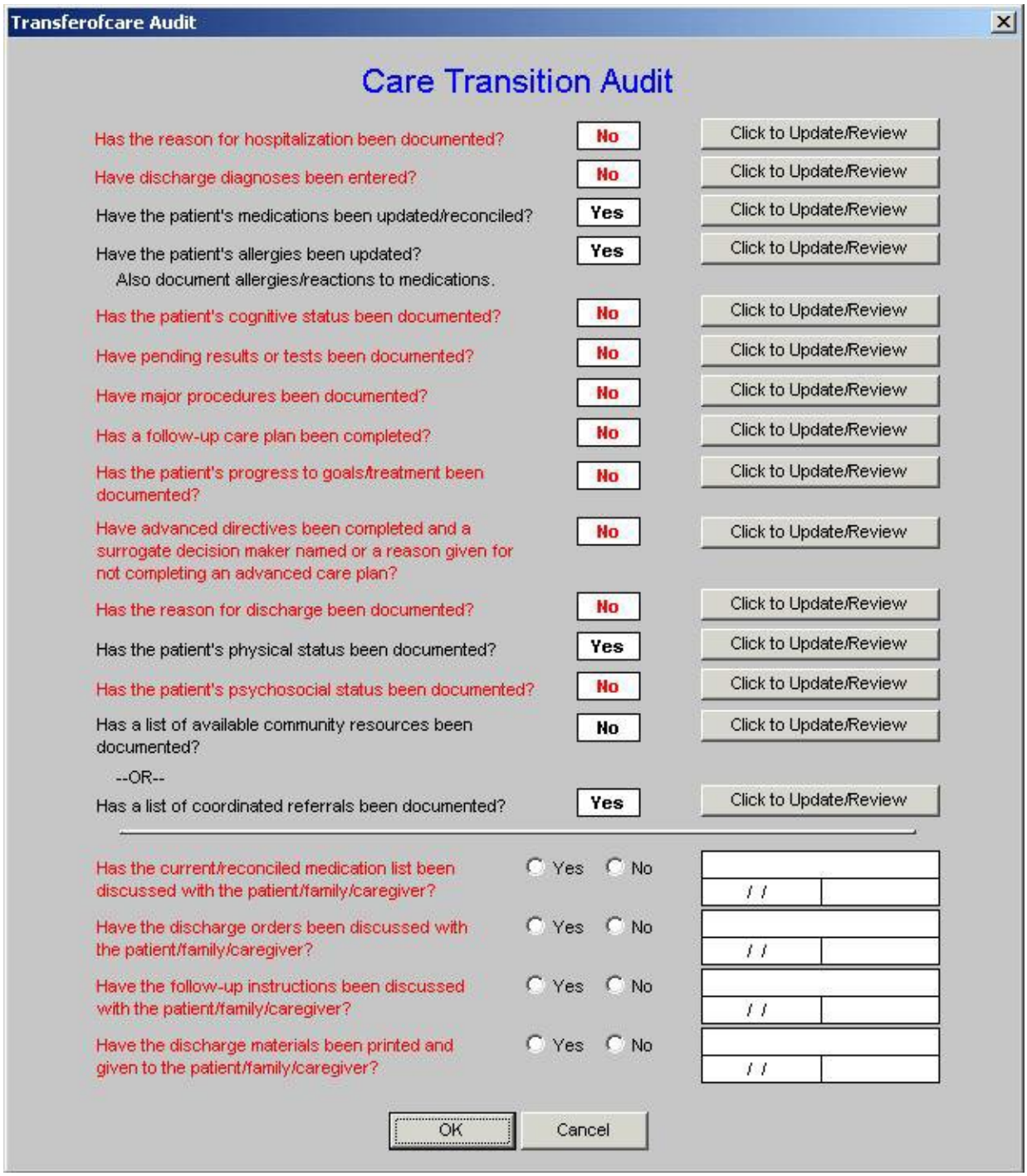
With SETMA's principles of quality improvement and the IOM's discussion of professional development, let's examine SETMA's 2011 initiative to reduce preventable readmissions to the hospital. Where are we starting?

1. SETMA treats almost one thousand patients in long-term residential care. Nationally, hospital admissions from nursing homes have risen to more than 10% of the population of nursing home residents, and readmission rates are over 19%. SETMA has effectively reduced nursing-home hospital admissions to less than 6% of the patients we care for and in one population of patients have reduced readmission rates to 2%. SETMA is currently deploying the recently published National Quality Forum quality measurement set for Long-term Resident Care. We believe that the 21 elements of this measure set will allow us to focus our attention even more on improve the quality of care and consequently the need to transfer patients to the hospital.
2. SETMA has reduced the overall readmission rates for Medicare Advantage beneficiaries to 11.6%. from a national figure of over 19%

Both our passed experience and our goals for the future are based on our analysis of the processes of healthcare delivery and of our development of those processes to support effective, safe and excellent care which will result in our reducing preventable readmission rates. What are the steps to that process:

1. Ten years ago, SETMA began using our EHR in the hospital to produce history and physical examinations for hospital admissions. This created a continuity-of-care pattern based on the patient's healthcare data.

2. Eight years ago, SETMA began using our EHR in the hospital to produce discharge summaries which further advanced the continuity of patient care. Eventually, we renamed the "discharge summary." The deficiency of the name "discharge summary" was that it only incidentally, but not intentionally,, dealt with the complex transitions of care issues created by moving from the inpatient or the emergency department to the ambulatory care arena or other place of other. The name was changed to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." More will be discussed about this later.
3. Eight years ago SETMA designed hospital admission order sets based on national standards of care which created a consistency of treatment plans. This act alone decreased SETMA's lengths of stay by almost 22 hours per hospitalization.
4. Eight years ago, SETMA began using the EHR in all twenty-two nursing homes we staff. Because our patients' care is managed in the same electronic data base, whether they are in the ambulatory setting, hospice, home health, physical therapy, hospital, emergency department, nursing home or other place, there is a continuity of care which is data and information driven. The
5. Two years ago, when the Physician Consortium for Performance Improvement published the first national quality measurement set on Care Transitions, set deployed it in our EHR. In June, 2010, SETMA deployed the PCPI Care Transitions measurement set. The following depicts that deployment in the EHR:



The legend is that all in black apply and are done; all in red apply and are not done.

From July, 2010 to March, 2011, SETMA discharged 2205 patients from the hospital. 99.1% of them had their Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan completed at the time of discharge with a copy being given to the patient, family or parent. The Transition of Care metric set has 14 data points and four actions. The following is our COGNOS audit for the year 2010 on these 18 quality metrics.

Transition of Care Measurement

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Transition of Care Measurement

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

Transition of Care Measurement

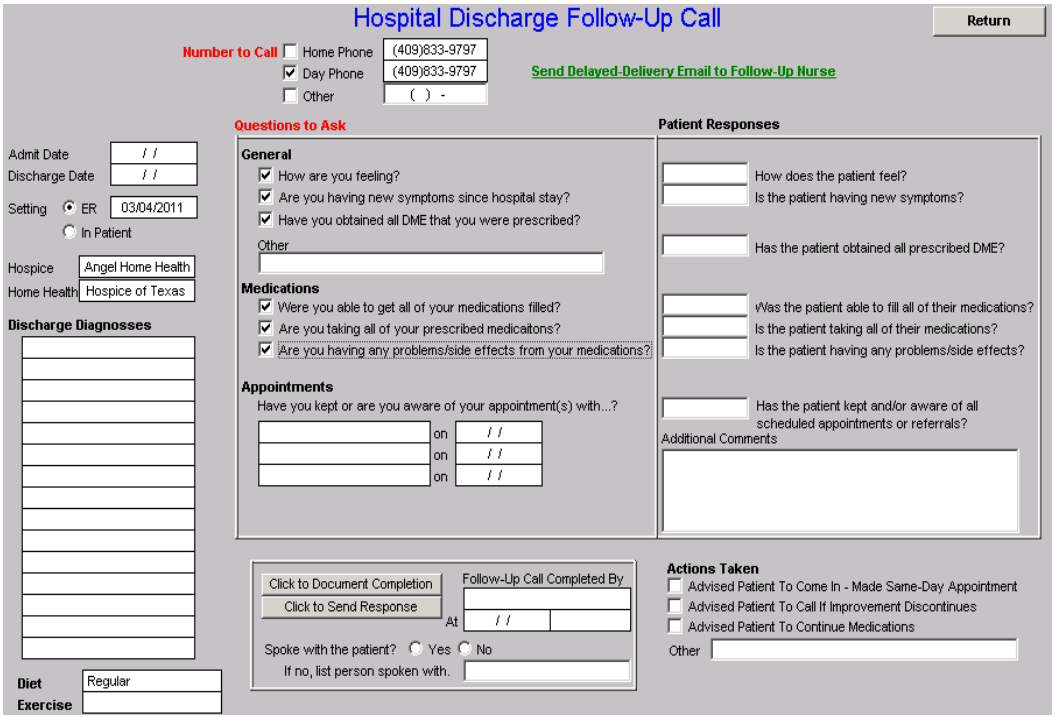
Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

6. In 2010, pursuit to SETMA become a Tier 3 PC-MH, we created a Department of Care Coordination. As part of that initiative, we began calling every patient discharged from the hospital. The call takes place the day after their discharge and involves a 12-30 minute call which addresses major transitions of care, patient safety, and quality of care issues. If after three attempts no telephone contact is made, a letter is automatically generated and mailed to the patient asking them to contact our office for follow-up.

Transition of Care Measurement



7. About the same time, SETMA designed a Business Intelligence audit of our hospitalized patients to examine differences between patients who are readmitted and those who are not. The BI audit looks at: gender, ethnicity, socio-economic issues, morbidities and co-morbidities, lengths of hospital stays, age, and rapidity of follow-up after discharge from hospital, whether a follow-up call was received and numerous other issues. All of these measures are looking for leverage points for "making a change which will make a difference."
8. Four years ago, SETMA's partners realized that many of our patients, even those with insurance cannot afford parts of their health care. Thus The SETMA Foundation was created. The partners have given over $1,000,000 to the Foundation which pays for medications, surgeries and other care such as dental for our patients who cannot afford it. For those whom we have been able to help, virtual miraculous results have been achieved.
9. 18 months ago, SETMA undertook to publicly report by provider name the results of our performance on over 200 quality metrics. In addition, the disease management plan of care for hypertension, cholesterol and diabetes includes the provider performance on each

individual patient's care as judged by these quality metrics. The former, without patient identification, are reported at www.jameslhollymd.com.

10. 12 years ago, SETMA realized that excellent care in the 21st Century was going to be team-based. As a result, we have a hospital service team which provides 24-hour a day, seven-days a week, in house health coverage for all of our patients. This team supports the healthcare providers and together, this team is achieving remarkable results. In the fall of 2011, we are going to increase the access of our patient to clinic in afterhours care so as to minimize the need for use of the emergency department further.
11. Six years ago, SETMA discovered that five different departments in SETMA were keeping paper records of patients admitted to the hospital in an effort to manage the business and professional activities related to these patients. Realizing that this is inefficient and ineffective, SETMA design the IMRC (Inpatient Medical Record Census). This is an electronic function which is deployed on SETMA's intranet. It is HIPPA compliant, secure and password protected by 128 bit encryption. When a patient is admitted to the hospital, the patient's name and place of admission is documented. Then the date of completion of the History and Physical examination is entered. This is done over 99% of the time on the date of admission. Then the date of discharge and date of completion of the Hospital Care Summary and Post Hospital Plan of Care and Treatment plan is documented. If the business office has a question in order to properly bill for services, they post it on the IMRC, the research is done and report to the Central Business Office.
12. SETMA has deployed both a secure web portal and a health information exchange to allow the seamless exchange of information between the hospitals and SETMA. Over the next five years, it is our hope to have all healthcare providers in a seven county area connected and sharing secure healthcare information.
13. SETMA partners with a Medicare Advantage home health agency and in a Stark-compliant manner with other home health agencies and with free-standing hospices to provide compassionate, competent care for our patients in settings other than the inpatient to reduce readmission from our most vulnerable patients.
14. The Hospital Care Summary and Post Hospital Plan of Care and Treatment is transmitted to the next site of care as follows:

    1) Inpatient to ambulatory outpatient (family) -- The "baton" in a printed format is given to the patient or in the case of a minor or incompetent adult to a parent or care giver. The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.
    2) Inpatient to ambulatory outpatient (clinic physician) -- for patients who are seen at SETMA, the "the baton" is created in the EHR and is immediately accessible to the follow-up SETMA provider. The provider is alerted by appointment when he/she is to see the patient and that the "baton" is available for review.
    3) Inpatient to ambulatory outpatient (follow-up call) -- after the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (HCSPHPCTP) is completed, a template is completed and sent to the Department of Care Coordination. This template is in the EHR where the HCSPHPCTP also resides. Both are immediately accessible to the Department. The "follow-up call from the hospital"

call request is delayed for one day so that the call is made the day after the patient leaves the hospital.

4) Emergency Department to ambulatory care -- the same process as in "1" above.
5) Inpatient to Nursing Home -- the "baton" with a special set of Nursing Home orders is given to the patient or family and a copy is sent to the Nursing Home with the transportation to the Nursing home.
6) Inpatient to Hospice -- the same as with number "6"
7) Inpatient to Home Health -- the same as number "5" and "6" above. If the patient is seeing MediHome, they have access to SETMA EHR and thus to the "baton."
8) Inpatient to outpatient out of area -- "Baton" given to patient and family and also posted to web portal and HIE. Token sent to health provider in remote area which allows one time access to this patient's information.

With this infrastructure and with these care coordination, continuity of care and patient support functions, we believe that we are ready to make a major effort to decrease preventable readmissions to the hospital. Each of these 14 steps is building the foundation for our quality initiative.

We believe that the improvements we achieve on this foundation will be sustainable. Two months ago, we discharged 26 patients in two days on the weekend. We have tracked these patients and have experienced 6.8% readmissions. We treated these patients, even though some of them were challenging discharges, through our established procedures and processes so as to have a valid snapshot of the results were are achieving. Sustainability is the key to quality improvement. The foundation we have built will allow us to sustain our efforts even after the initiative is complete. We look forward to monitoring our results over the next three years.

Patient-Centered Medical Home and Care Transitions
Part I
By James L. Holly, MD
Your Life Your Health
The Examiner
April 21, 2011

As the nation grapples with the theory of the future of healthcare, some of us are experimenting not only with ideals but with practical solutions. At SETMA, we believe that the future of healthcare has four domains, which must be addressed in any solution which will be sustainable. They are:

1. **The Substance** -- Evidenced-based medicine and comprehensive health promotion
2. **The Method** -- Electronic Patient Management
3. **The Organization** -- Patient-centered Medical Home
4. **The Funding** -- Capitation with payment for quality outcomes

Billions paid each year for care which is not evidence-based

The first of these domains is affirmed by everyone but only as an ideal. Evidence-based medicine refers to treatments which have been shown to be effective by random-controlled, research studies. These studies are rigorously designed and subjected to peer-review for that design, for the data developed and for the conclusions. Everyone agrees that this should be the foundation of healthcare but healthcare providers, the Federal Government, insurance companies and patients still prescribe, pay for and participate in treatments which not only are not supported by research but which are shown by research to be harmful. Billions of dollars are paid each year for such services, often for no other reason than the strong lobby supported by industries that profit from those services.

Recently, this writer asked a Federal healthcare official if the Centers for Medicare and Medicaid (CMS), which is the largest insurance company in the world, supports only evidenced-based medicine? His response was, "Yes." The follow-up question was asked, "Are you and CMS committed to change the trajectory of healthcare cost in the United States?" He answered, "Yes." The final question was, "Then why are we paying billions of dollars a year for a form of healthcare which is not supported by evidence?" His response, "Because it is legal in all states." There is no element of evidence-based medicine which involves a question of legality. Stated another way, whether a treatment modality is legal or not is not a criteria by which to determine whether it is evidenced-based. Until CMS and the healthcare industry stops paying for non-scientific healthcare, we will never solve healthcare cost in this country. Until politicians stand up to lobbyists paid for by providers of non-scientific healthcare modalities, we will never solve the healthcare cost in this country.

Comprehensive Wellness Promotion

When I began practicing medicine in 1973 essentially no payments were made for wellness promotion. When Medicare was made law in 1965, provision for payments was made for illness

care. Preventive healthcare was not often paid for. Screening healthcare was not paid for. Immunizations were not always paid for. And, there was little if any focus on wellness. This was before we had screening tests like colonoscopies so anyone who needed to have their colon examined had to have a "barium enema." The only problem was that insurance would only pay for this test if it was done in the hospital. Consequently, patients often demanded to be put in the hospital. In that case, an $80 test resulted in an $800 cost.

The situation is a little better today but it is still far from ideal. Like evidence-based medicine, comprehensive wellness is promoted by everyone but not paid for by many. Wellness promotion has to do with surveillance and screening for illness and with the encouragement of healthy lifestyles and choices. Like some many other areas in our economy, what we value, we pay for and we pay well. Thus, don't ask what our society values, as we will get one answer. Ask what we pay for and how well we pay for it and you will find what we really value.

Electronic Patient Management

The second domain of healthcare transformation is the deployment of electronic tools with which to management the care of patients. When SETMA started doing "electronic-patient-management" (EPM) using electronic-health-records (EHR) in 1998, we applied Dr. Peter Senge's work in *The Fifth Discipline* to medicine and particularly to the design of an EHR. The link http://www.jameslhollymd.com/The-Fifth-Discipline-and-Electronic-Patient-Records.cfm will take you to multiple articles about our application of his work to medicine. This innovation in the design and deployment of EHR has led SETMA to be named by the Office of National Coordinator, HIT, HHS, as one of thirty exemplary practices in clinical decision support. Other recognitions of our work are displayed at www.jameslhollymd.com under the heading Awards and Recognitions.

Key to EPM is Senge's idea that "learning has come to be synonymous with 'taking in information'… (which) is only distantly related to real learning." Today healthcare can:

- "Create more information than anyone can absorb
- "Foster greater interdependency than anyone can manage
- "Accelerate change faster than anyone's ability to keep pace."

Just as "paper-and-pencil" was the methodology for 19th Century healthcare and "dictation" was the methodology for 20th Century medicine, "EPM-via-EHR" is the only effective methodology for 21st Century healthcare. At SETMA's website www.jameslhollymd.com under ***Your Life Your Health***, there is an icon entitled ***Medical Records***. By accessing this hyperlink you will find twenty-two articles on the concepts of electronic-patient-management by electronic-health-records. This is the future of healthcare and it started in the 1990s.

Patient-Centered Medical Home (PC-MH)

The third domain of healthcare transformation is PM-MH. At www.jameslhollymd.com under ***Your Life Your Health*** there is another icon entitled ***Medical Home***. By accessing this hyperlink, you will find 33 articles on PC-MH. The major principles of PC-MH are:

1. Comprehensive Wellness Promotion
2. Coordination of Care producing Coordinated Care
3. Collaboration between the healthcare provider and the healthcare recipient
4. Communication between the healthcare provider and the healthcare recipient at times other than when the patient is in the provider's office
5. Calculation of healthcare risk in order to provide optimal care
6. Compilation of healthcare data for individual patients and for populations of patients in order to find leverage points for improving everyone's care.
7. Constant innovation to find new, effective and scientifically sound ways of promoting health and wellness, and restoring health when it has been lost.

There are few places where the ideals of PC-MH are as clearly needed and as clearly seen as at the points of "transitions of care" from one setting of care to another, such as:

1. Hospital inpatient to Ambulatory Outpatient.
2. Ambulatory outpatient clinic to ambulatory outpatient home
3. Hospital inpatient to long-term, residential care (Nursing Home)
4. Many more

It is at these points that the imperative for care in a PC-MH model of care is most clearly seen. It is at these points where the quality of care is most often diminished or even lost. It is by examining these points that the "organizational domain" of the future of healthcare can be best examined.

Care Transitions

In **SETMA's Model of Care** (for a full description see SETMA's presentation to the Office of National Coordinator at the following link: http://www.jameslhollymd.com/The-Future-of-Healthcare.cfm), **Care Transitions** involves:

- Fulfillment of the Physician Collaborative for Performance Improvement (**PCPI) Transitions of Care Quality Metric Set** which has fourteen data points and four action items.
- **Post Hospital Follow-up Call** which is a 12-30 minute call which takes place the day after the patient leaves the hospital which is made by members of SETMA's **Care Coordination Department**.
- **Plan of Care and Treatment Plan**, which is symbolized by the "baton."
- **Follow-up visit** with primary provider in less than seven days of discharge and usually within three.

Over the past fourteen years, SETMA has developed numerous tools which enable us to sustain an effort to impact preventable readmission rates. In June, 2009, the PCPI published a quality metric set on Transitions of Care. Because SETMA had been completing hospital history and physicals and discharge summaries in the EHR, we were prepared to deploy this measurement set. We have been successfully doing so since that time with 6,147patients discharged from the hospital.

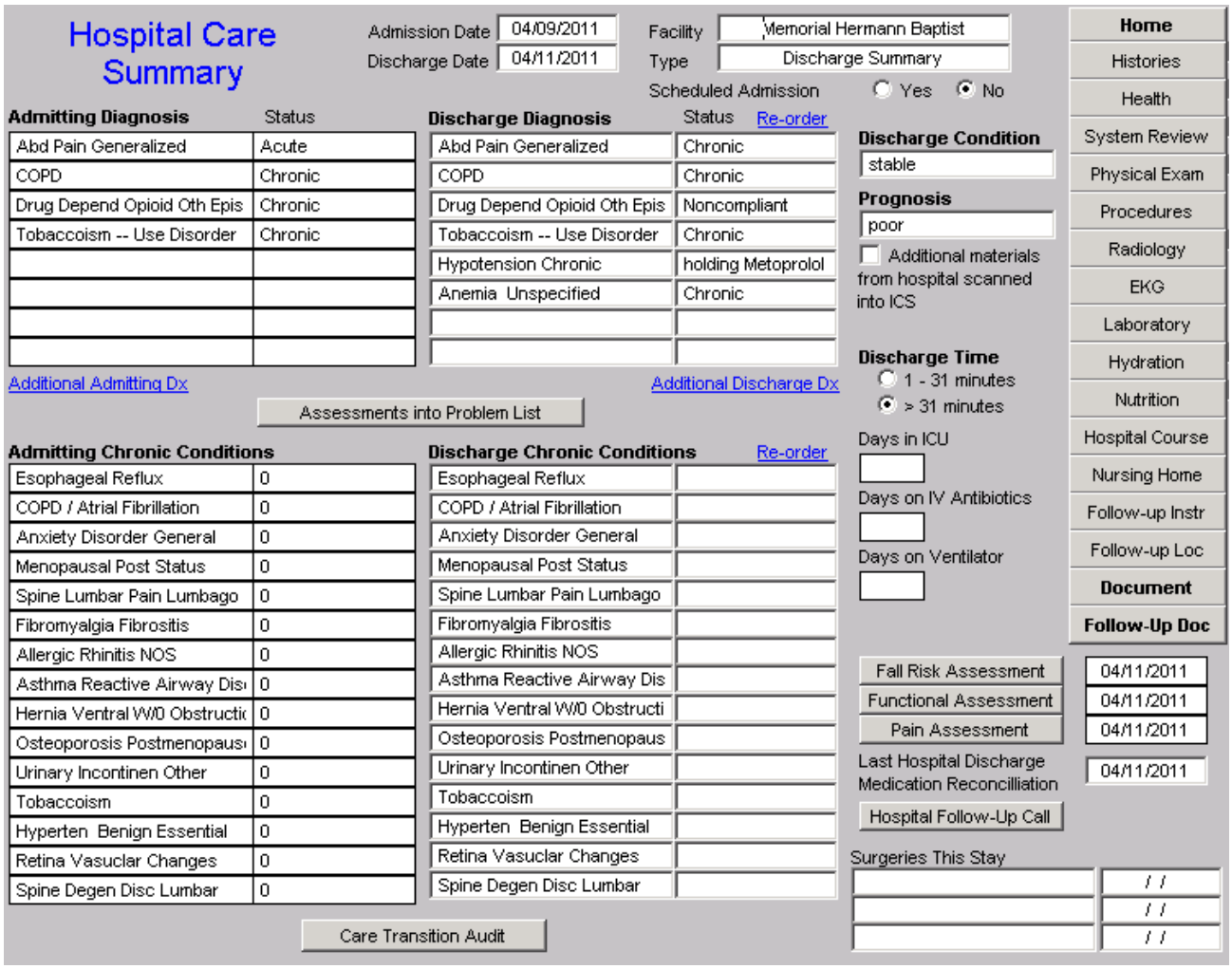
Changing the Name of the "Discharge Summary"

In September, 2010, at a National Quality Forum workshop of Care Transitions in Washington, it occurred to us that the name "discharge summary" was outdated and not helpful. The document had become almost an administrative function, often completed weeks after the patient left the hospital. It was not the critical element in the patient's moving from their inpatient or emergency department state to the ambulatory or other setting.

We immediately changed the name of that document to "**Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan**." This is a long and perhaps awkward name, but it is extremely functional, focusing on the unique elements of Care Transition. From June, 2009 to April, 2011, SETMA has a 99.1% rate of completing this document at the time the patient leaves the hospital. During this time we have discharged 6,147 patients from the hospital.

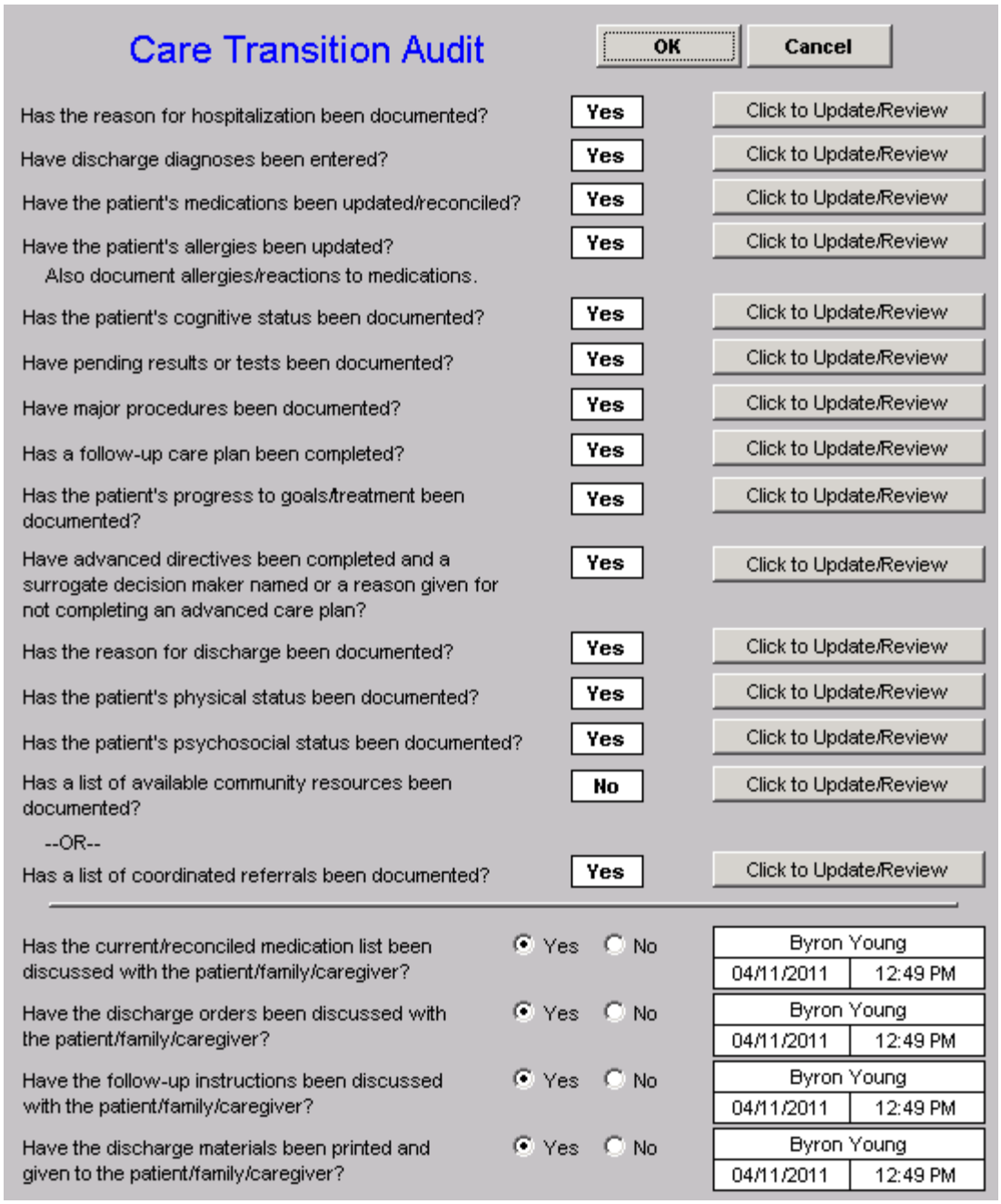
Hospital Care Summary

This is a suite of templates with which the discharge document is created. (For a full description of this see the following on SETMA's website: **Electronic Patient Tools; Hospital Care Tools; Discharge Summary Tutorial**) The following is a screen shot of the **Master Discharge Template** entitled "**Hospital Care Summary**". This screen shot is from the record of a real patient whose identify has been removed.



At the bottom of this template you will see a button entitled "**Care Transitions Audit**." Once the suite of templates associated with the Hospital Care Summary has been completed, the provider depresses this button and the system automatically aggregates the data which has been documented and displays which of the 18-data points have been completed.

The elements in black have been completed; any in red have not.



If an element is incomplete, the provider simply clicks the button entitled "**Click to update/Review**." The missing information can then be added. This fulfills one of SETMA's principles of EHR design which is "**We want to make it easier to do it right than not to do it at all**."

At appropriate intervals, usually quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely. This reporting

is done by provider name. The following is the care transition audit results by provider name for 2010. This presently is posted on our website. The audit is done through SETMA's COGNOS Project which is described in detail on our website under **Your Life Your Health** by clicking on the icon entitled **COGNOS**.

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

Once the **Care Transition** issues are completed, the **Hospital-Care-Summary-and-Post-Hospital-Plan-of-Care-and-Treatment-Plan** document is generated and printed. It is given to the patient and to the hospital. The complexity of the **Transition of Care** is illustrated by this analysis of how many different places this document can be needed. It can go from:

1. **Inpatient to ambulatory outpatient** (family) -- The "baton" in a printed format is given to the patient or in the case of a minor or incompetent adult to a parent or care giver. The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.
2. **Inpatient to ambulatory outpatient** (clinic physician) -- for patients who are seen at SETMA, the "the baton" is created in the EHR and is immediately accessible to the follow-up SETMA provider. The provider is alerted by appointment when he/she is to see the patient and that the "baton" is available for review.
3. **Inpatient to ambulatory outpatient** (follow-up call) -- after the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (HCSPHPCTP) is completed, a template is completed and sent to the Department of Care Coordination. This template is in the EHR where the HCSPHPCTP also resides. Both are immediately accessible to the

Department. The "follow-up call from the hospital" call request is delayed for one day so that the call is made the day after the patient leaves the hospital.

4. **Emergency Department to ambulatory care** -- the same process as in "1" above.
5. **Inpatient to Nursing Home** -- the "baton" with a special set of Nursing Home orders is given to the patient or family and a copy is sent to the Nursing Home with the transportation to the Nursing home.
6. **Inpatient to Hospice** -- the same as with number "6"
7. **Inpatient to Home Health** -- the same as number "5" and "6" above. If the patient is seeing SETMA's home health, they have access to SETMA EHR and thus to the "baton."
8. **Inpatient to outpatient out of area** -- "Baton" given to patient and family and also posted to web portal and HIE. Token sent to health provider in remote area which allows one time access to this patient's information.

With this infrastructure and with these care coordination, continuity of care and patient support functions, SETMA is ready to make a major effort to decrease preventable readmissions to the hospital.

Patient-Centered Medical Home and Care Transitions
Part II
By James L. Holly, MD
Your Life Your Health
The Examiner
April 28, 2011

The complexity of the **Transition of Care** is illustrated by this analysis of how many different places this document can be needed. It can go from:

1. **Inpatient to ambulatory outpatient** (family) -- The "baton" in a printed format is given to the patient or in the case of a minor or incompetent adult to a parent or care giver. The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.
2. **Inpatient to ambulatory outpatient** (clinic physician) -- for patients who are seen at SETMA, the "the baton" is created in the EHR and is immediately accessible to the follow-up SETMA provider. The provider is alerted by appointment when he/she is to see the patient and that the "baton" is available for review.
3. **Inpatient to ambulatory outpatient** (follow-up call) -- after the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (HCSPHPCTP) is completed, a template is completed and sent to the Department of Care Coordination. This template is in the EHR where the HCSPHPCTP also resides. Both are immediately accessible to the Department. The "follow-up call from the hospital" call request is delayed for one day so that the call is made the day after the patient leaves the hospital.
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7. **Inpatient to Home Health** -- the same as number "5" and "6" above. If the patient is seeing SETMA's home health, they have access to SETMA EHR and thus to the "baton."
8. **Inpatient to outpatient out of area** -- "Baton" given to patient and family and also posted to web portal and HIE. Token sent to health provider in remote area which allows one time access to this patient's information.

With this infrastructure and with these care coordination, continuity of care and patient support functions, SETMA is ready to make a major effort to decrease preventable readmissions to the hospital.

The document generated once the care transition issues are met, in part looks like the following. The full document includes reconciled medications, follow-up appointments with time, dates, address and provider name and any referrals which have been initiated as a result of the hospitalization.

The Baton

"The Baton" is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race. It is the instrument through which responsibility for a patient's health care is

transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

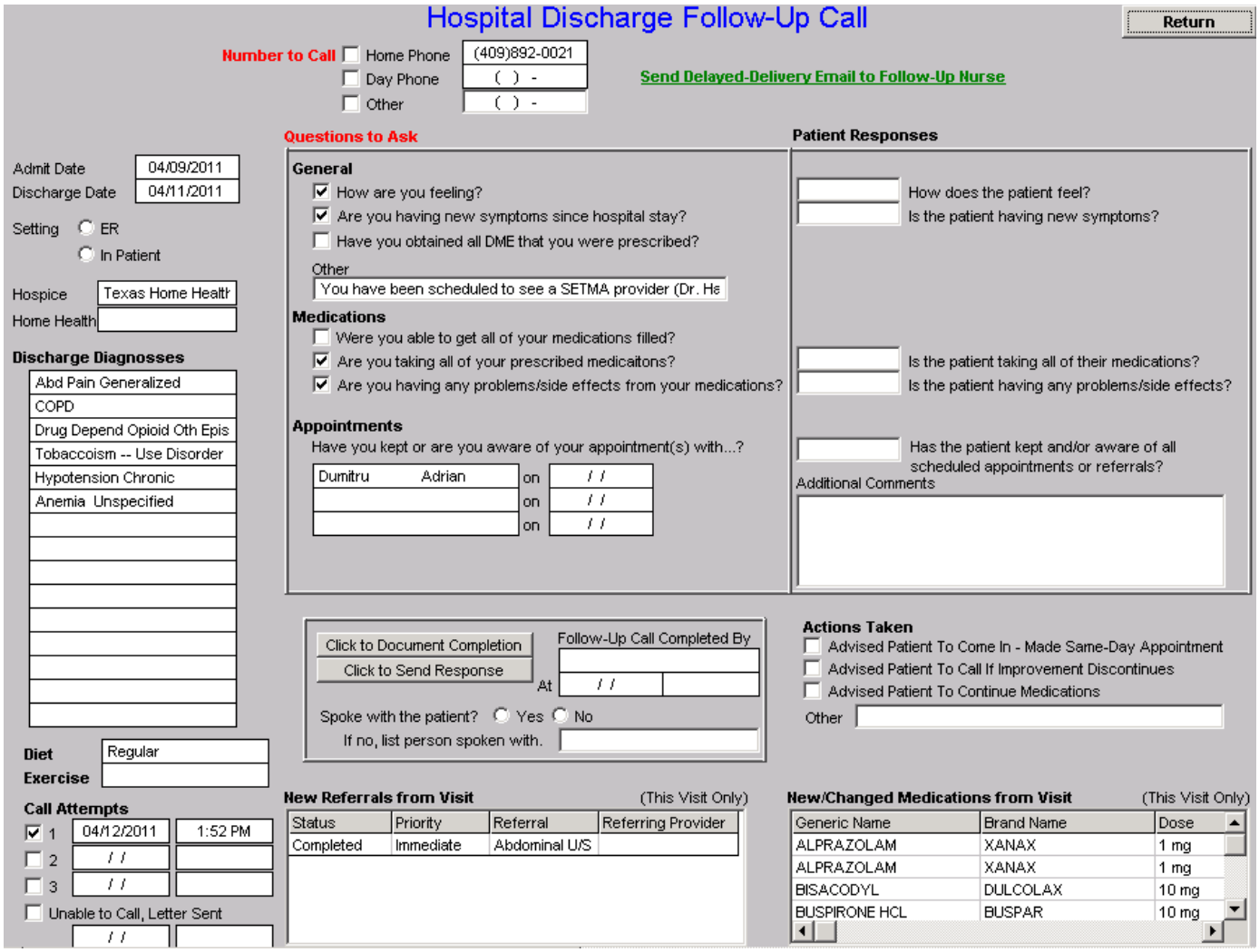
The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display continually reminds the provider and will inform the patient, that to be successful, the patient's care must be **coordinated**, and must result in **coordinated care**. In 2011, as we expand the scope of SETMA's Department of Care Coordination, we know that coordination begins at the points of "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute that plan.

Hospital Follow-up Call

After the care transition audit is completed and the document is generated, the provider completes the **Hospital-Follow-up-Call** document:



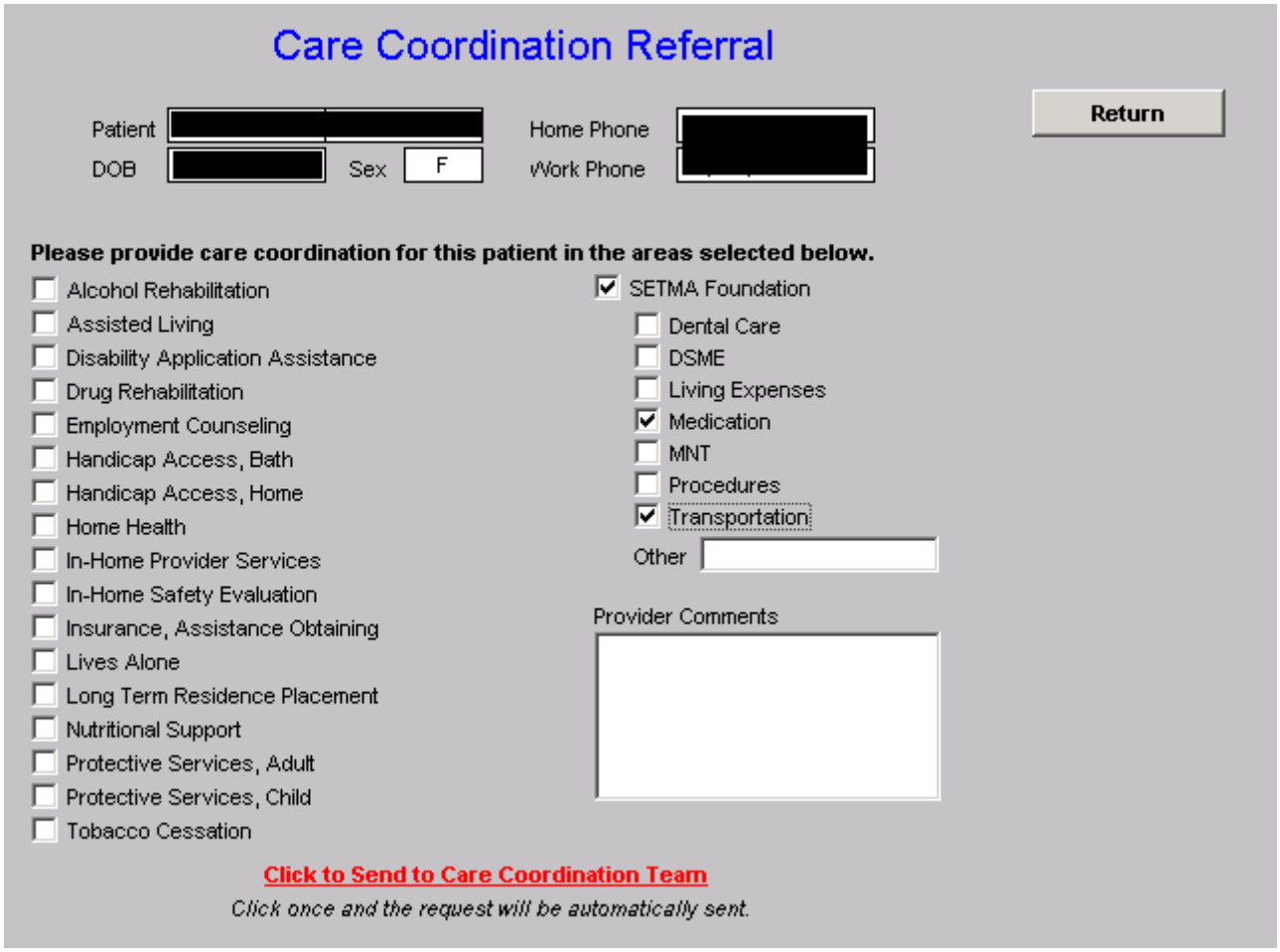
During that preparation, the provider checks off the questions which are to be asked the patient in the follow-up call. The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called. This call is a beginning of the "coaching" of the patient to help make them successful in the transition from the inpatient setting to their next level of care. After the call is completed, the answers to the questions are sent back to the primary care provider by the care coordinator. If the patient has any unresolved issues or is having any problem, he/she is given an appointment that same day.

The Care Coordination takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care. If appropriate, an additional call is scheduled at an appropriate interval. If after three attempts, the patient is not reached by phone, the box in the lower left-hand corner by "**Unable to Call, Letter sent**" is checked. Automatically, a letter is created which is sent to the patient asking them to contact SETMA.

Follow-up Visit with Primary Care Provider

The Transition of Care is complete only when the patent is seen by the primary care provider in follow-up. Many issues are dealt with in this follow-up visit, but one of them is another potential

referral to the Care Coordination Department. If the patient has any barriers to care, the provider will complete the following template. In the case of this patient, with the checking of three buttons the need for financial assistance with medications and with transportation is communicated to the Care Coordination Department by clicking the button in red entitled, "Click to Send to Care Coordination Team."



The SETMA Foundation and Patient-Centered Medical Home

Four years ago the partners of SETMA formed **The SETMA Foundation**. This Foundation provides funding for health care for our patients who cannot afford it. In the past 16 months, the partners of SETMA have contributed $1,000,000 to the Foundation and the results in the lives of our patients have been miraculous. The following is an illustration of the union of Care Transitions, Care Coordination, The Foundation and PC-MH.

Under the Medical Home model the provider has NOT done his/her job when he/she simply prescribes the care which meets national standards. Doing the job of Medical Home requires the prescribing of the best care which is available and accessible to the patient, and when that care is less than the best, the provider makes every attempt to find resources to help that patient obtain the care needed. In February 2009, SETMA saw a patient who has a very complex and

fascinating healthcare situation. When seen in the hospital as a new patient, he was angry, bitter and hostile. No amount of cajoling would change the patient's demeanor.
During his office-based, hospital follow-up, it was discovered that the patient was only taking four of nine medications because of expense; could not afford gas to come to the doctor; was going blind but did not have the money to see an eye specialist; could not afford the co-pays for diabetes education and could not work but did not know how to apply for disability.

After his office visit, he left SETMA with our Foundation providing:

1. All of his medications. The Foundation has continued to do so for the past two years at a cost of $2,200 a quarter. In September, his Medicare benefits will begin after two years of being disabled.
2. A gas card so that he could afford to come to multiple visits for education and other health needs.
3. Waiver of cost for diabetes education with SETMA's American Diabetes Association accredited Diabetes Self Education and Medical Nutrition Therapy program.
4. Appointment to an experimental vision preservation program at no cost.
5. Assistance with applying for disability.

Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not; but, are they a part of Medical Home? Absolutely! This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with help. He returned six-weeks later. He had a smile and he had hope. It may be that the biggest result of Medical Home is hope. And, his diabetes was treated to goal for the first time in ten years. He has remained treated to goal for the past two years. Every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources is a part of medical home. And, when those resources cannot be found, Medical Home will be "done" by modifying the treatment plan so that what is prescribed can be obtained. **The ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare, even if the plan of care is up to national standards.**

Care Transition is the heart of the patient-centered medical Home. It fulfills many of the elements of the National Priorities Partnership in which the National Quality Forum identified Priorities for the 2011 National Quality Strategy. These are:

- Wellness and Prevention
- Safety
- Patient and Family Engagement
- Care Coordination
- Palliative and End of Life Care

These are SETMA's goals. We shall see how well we do.

SETMA: Practices in the Spotlight
Medical Home and Diabetes Care
By James L. Holly, MD
Your Life Your Health
The Examiner
April 7, 2011

During the week of March 28th to April 1, 2011, Dr. Holly was in Washington, D.C. speaking at the Stakeholder's Workshop of the Patient-Centered Primary Care Collaborative PC-PCC) and also the Office of National Coordinator of Health Information Technology (ONC), a section of the Department of Health and Human Services. In a new publication entitled *Practices in the Spotlight: The Medical Home and Diabetes Care*, PC-PCC published a case study on ten practices selected for "the spotlight." SETMA was one of these.

The report was developed by Health2Resources on behalf of PC-PCC. Outside of key PC-PCC staff, two diabetes expert panelists served in this development Richard Jackson, MD, Director of Medical Affairs, Healthcare Services Strategic Initiatives at the Joslin Diabetes Center and Donna Tomky, MSN, RN, C-ANP, CDE, F.A.A.D.E, President, American Association of Diabetes Educators.

The report states:

"Recognition/Programs:

- " Joslin Diabetes Center Affiliate
- " NCQA Diabetes Recognition Program
- " NCQA-recognized Level 3 Medical Home
- "Accreditation Association for Ambulatory Health Care Medical Home Accreditation

"Southeast Texas Medical Associates (SETMA) is a multi-specialty medical practice with four clinical locations in Southeast Texas. Its diabetes management program, in place since 2000, serves 7,232 patients. It is directed by 24 physicians and 14 nurse practitioners, and supported by 13 RNs, 26 LPNs, seven medical assistants, a certified diabetes educator, two nutritionists and two physical therapists.

"The progress towards excellence in diabetes care began with the development of a custom diabetes disease management tool in 2000. In 2004, the practice received recognition by the American Diabetes Association of its diabetes self-management education program. SETMA extended its diabetes expertise with the addition of an endocrinologist in 2006. In 2009, the adoption of COGNOS Business Intelligence data mining software allowed SETMA to audit populations of patients, and to understand and compare the processes and outcomes of care delivered to all of its patients, tracking data by ethnicity, gender, socioeconomic standing and other categories. This dedication to quality measurement and improvement earned SETMA an affiliation with the Joslin Diabetes Center, the renowned research and clinical care organization affiliated with Harvard Medical School, in 2010.

“Anticipating the complexity of 21st century health care, SETMA adopted a system-wide health information technology system in 1998 with an eye toward supporting quality improvement efforts in a cost-effective manner. When asked to identify his practice’s top success elements, SETMA CEO, James L. Holly, MD, referenced the value of the customized disease management tool and electronic medical record that actively support SETMA’s quality improvement program.

“After three months of using the EMR, we realized that it is too expensive and too hard to use, if all we get from it is the ability to document a patient encounter,” Holly said. “We wanted to bring to bear upon every patient evaluation what is known about a condition in order to improve quality outcomes.” By building customized disease management tools that tap into clinical data, SETMA improved patient HbA1c results. Improvement for HbA1cs across the practice was .36 percent in the first year, and SETMA has seen consistent improvement year over year for more than a decade. From 2000 to 2010, the mean HbA1c was reduced from 7.8 percent to 6.54 percent. The standard deviation for all patients with HbA1c went from 1.98 to 1.2. SETMA’s goal is a standard deviation of 0.8.

“SETMA’s Model of Care begins with tracking of provider performance in real time on more than 200 quality metrics on every patient seen every day. Then SETMA audits each provider’s performance on all patients seen each day. Third, SETMA analyzes the audit data through COGNOS BI tools to look for leverage points to improve population care. The fourth step is the public reporting of provider performance by provider name. From these four steps, SETMA designs quality improvement initiatives.

“Perhaps the most unique aspect of SETMA’s Model of Care is its transparency. SETMA gives all patients the results of their quality-metric audit at the end of each visit. In January 2010, SETMA began publicly reporting more than 200 quality metrics (including those related to diabetes care) by individual provider name. The numbers are updated on the SETMA website on a quarterly basis, but providers can see their individual data every day in the COGNOS system and compare it to their colleagues. ‘Every doctor in America believes they are doing a good job, but typically the data is not as good as they think,’

“Holly said. ‘It’s amazing how clinical inertia in SETMA has changed because of public accountability. We believe that the piece missing in quality metrics analysis is public reporting. Across the country, there are eight different diabetes quality metric sets, and we track all of them because they are all different. There is not a bad element in any of them, but we are encouraging that the different organizations harmonize their metrics with the metrics of others. Until you are tracking performance at the point of care, and until you give providers the ability to see how they perform, and until you publicly report that performance, it’s not enough.’

“The quality tracking, auditing, analysis and reporting are ultimately aimed at improvement in care. SETMA’s current goal is to successfully treat all patients with diabetes to goal and to sustain its having achieved the elimination of ethnic disparities in diabetes care. This year SETMA has an aggressive plan for intervening in the care of Caucasians and African-Americans in the practice, who are not controlled.

“Because diabetes education is a crucial element to better health, SETMA equips patients with tools for successful self-management. SETMA’s ‘Seven Stations for Success’ is a formalization of the idea that a patient is ‘in charge of his or her own health care 8,760 hours a year,’ Holly said. The stations emphasize the medical-home principles of partnering in care and in comprehensive and coordinated care.

“The Seven Stations are posted in the hallway of SETMA’s diabetes clinic. Then each station is posted in numerical order corresponding to how a patient typically moves through a routine diabetes visit. The first station addresses self-monitoring of blood glucose where the patient downloads their glucose monitor log. This station prompts patients to ask the diabetes educator to help create a plan for finding patterns in blood glucose readings. The second station is where the patient’s point-of-service HbA1c is measured and the patient is reminded of the benefits of keeping the HbA1c reading below 7%.

“Station three reminds the patient of his or her responsibility to lose weight, exercise and stop smoking. SETMA provides a calculation of the patient’s basal metabolism rate, body mass index and disease risk of their current weight at each appointment. A personalized exercise program is presented, along with an assessment of their use of or exposure to tobacco smoke. Station four points the patient to medical nutrition therapy and diabetes self-management education. Station five reminds patients that they work in partnership with their physician to set goals, determine risks for complications and plan for preventing complications.

“Station six focuses on coordinating referrals for other elements of diabetes care—from scheduling visits for diabetes education, dilated eye exams, nephrology care and physical therapy to coordinating needed resources. A practice director of care coordination and nurse care coordinators are tasked solely with keeping in touch with patients to ensure all care needs are met. ‘If they find patients who can’t afford medications, then we pay for it,’ Holly said. The SETMA Foundation, formed in 2007, is a separate non-profit organization, partially funded by the practice partners but also accepting contributions from outside entities, that pays for unmet patient needs. ‘We are seeing transformative change with that,’ Holly said. In 2009 and 2010, the partners gave a total of $1,000,000 to the Foundation.

“Station seven’s message is posted to the back of the exit door, and is the final visual reminder for patients leaving the practice. It is entitled, ‘You are Home: SETMA is YOUR Medical Home,’ and advises patients that they can communicate with their primary care provider during a visit, with a phone call, by email or letter. It also reminds the patient not to leave the clinic until they are confident that they are prepared to manage their care until their next visit or contact with their health care team.

“’That’s part of passing the baton to the patient,’ Holly said, referring to another visual he uses with patients, the hand-to-hand passing of a runner’s relay baton. The baton represents the patient’s plan of care and the treatment plan, or the instrument through which responsibility for care is transferred to the patient.

“The Seven Stations for Success draw heavily from the learning SETMA has taken from its Joslin Diabetes Center affiliation. The idea for patient education going forward is to change patient behavior by demonstrating clearly that a small change on the patient’s part can make a big difference in his or her health. ‘We know what our patients’ risks are, and so if we change the elements of those risk calculations, how will that change their result? We are now able to tell patients what their current status is, and can show them how to improve their health by changing each of the elements of the risk score. It will show the percentage of risk change if they just stop smoking, or just improve blood pressure. Then we put it into the treatment plan,’ he said. ‘The treatment plan is the ‘baton’ we use for passing healthcare responsibility back to the patient. If we’re not engaging, empowering, enabling them to care for themselves with that knowledge—that baton—then they’re going to lose the race.’”

Over-diagnosis – THE Problem?
By James L. Holly, MD
Your Life Your Health
The Examiner
May 19, 2011

Whether you favor health reform through external governmental pressure, or healthcare transformation through the generative power of personal passion and drive, no one is in favor of the status quo in healthcare delivery in the United States. Everyone who cares about the USA wants Americans to be healthier. On these premises, would we not all embrace a method of improving health which involves no cost; which actually creates tremendous savings in healthcare, and which can be instantly implemented without delay?

Dr. H. Gilbert Welch, Professor of Medicine at the Dartmouth Institute for Health Policy and clinical Practice, has "the way." His solution is to change the "diagnostic and treatment thresholds" for illness, thus making fewer people ill by definition. He further argues in a newspaper column for the *Los Angeles Times* and the McClatchy-Tribune news service, "To have any hope of controlling health care costs, 'doctors will have to raise their diagnostic and treatment thresholds'. And higher thresholds would be good for more than the bottom line. Less diagnosis and treatment of disease would return millions of Americans to normal, healthy lives. That's right: Higher thresholds could well improve health."

The philosophical question at the root of Dr. Welch's idea is, "Do definitions create reality, or only describe or define an objective reality?" And secondly, "Would simply changing the definition of health effect objective change in the state of an individual's health?" Dr. Gilbert would have us think it does. He asserts that, "Diagnostic thresholds that are set too low lead in turn to a bigger problem: treatment thresholds that are too low. Diagnosis is the critical entry step into medical care – getting one tends to beget treatment. That's a big reason why we are treating millions more people for high blood pressure, diabetes, osteoporosis, glaucoma, depression, heart disease – and even cancer." Dr. Gilbert's colleagues and students delight in his clever and novel ideas. "Hurray," they shout, "the solution to the healthcare problem in American is as simple as a definition." If we tell you you are not sick; if we tell you you are not at risk of getting sick; you no longer have to be concerned about your health. Problem solved.

The pesky problem with this is science and facts. In 1880, no one was diagnosed with diabetes. Did the first mention of a condition which was probably diabetes in 1200 BC, or the postulation that it was due to excess sugar in the blood in the late 19th century create, diabetes or did these developments describe a condition that exists whether we define and acknowledge it or not? Has the expansion of our knowledge about diabetes created the diabetes epidemic in the world? Have the scientifically-based thresholds for establishing the presence of diabetes, i.e., the new definition of diabetes, further aggravated the problem?

Would people be healthier if we did not tell them they have diabetes? Would those people who are not being treated for diabetes because we raise the threshold for its diagnosis, thus telling them that by definition they don't have diabetes, truly be healthy, or would they just be unaware of their illness and deteriorating health? Would their lives be better because they are unaware

that untreated, diabetes will result in serious, irreversible consequences, which will cause their death? When Dr. Elliott Joslin founded the Joslin Diabetes Center in 1898, the life expectancy of a patient with Type 1 diabetes after diagnosis was four months. Did he create the avalanche of cost which in 2007 resulted in $174 billion in costs of diagnosed diabetes in the United States? Has the refinement of the definition of diabetes – the diagnostic threshold – aggravated this problem?

Surprisingly, the answer to Dr. Welch is found in the business-administration literature. In his seminal work, *The Fifth Disciple*, Dr. Peter Senge addresses the issue of "dynamic complexity." He concluded, "When obvious interventions produce non-obvious consequences, there is dynamic complexity." He defines it as "where cause and effect are subtle, and where the effects over time of interventions are not obvious." This is the nature of diabetes. It doesn't hurt and has few symptoms early on. The benefits of the excellent treatment of diabetes are largely seen many years after its onset. Could anything more clearly define the nature of a disease like diabetes? If we change the threshold for the definition of diabetes, fewer people will "have diabetes," by definition, but the subtle processes which are destroying their health will continue until the non-obvious consequences become obvious but only after it is too late to do anything about it. The cost of treating diabetes will go down in the short run but the cost will skyrocket as the consequences of delaying treatment due to our new threshold become abundantly obvious. Changing the threshold for the defining of the presence of an illness does not change the reality of that illness, whether it is blood pressure, diabetes, heart disease or cancer.

Dr. Welch's philosophy is the basis of his theory. He detailed it in his book, *Over-diagnosed: Making People Sick in the Pursuit of Health*. He said, "Finally, there's our medical culture. We are trained not to miss things, however unimportant those things are. And we are trained to focus on the few we might be able to help, even if it's only 1 out of 100 (the benefit of lowering cholesterol in those with normal cholesterol but elevated C-reactive protein) or 1 out of 1000 (the benefit of breast and prostate cancer screening). We believe this is what our patients – and the public – cares about. But it's time for everyone to start carrying about what happens to the other 999." Dr. Welch thinks it's the group, not the individual, which is the valued object of society. Therefore, anything which does not help "the group" should be "defined" out of existence. The group's economic benefit – lowering the cost of healthcare by lowering the number of people who are treated because we change the definition of health and illness – is paramount. Dr. Welch's proposals for changing healthcare have much more to do with his political and social philosophy than with science and evidence-based medicine.

Finally, Dr. Welch argues that the establishment of diagnostic and treatment thresholds is the result of our quest for excellence in healthcare. He states: "The movement to measure health-care quality, however well intended, exacerbates the problem. Many performance metrics measure whether diagnostic tests and treatments are being ordered. Because good grades require actions, not inactions, lower thresholds are encouraged. And the advent of electronic medical records has made these actions even easier, as more and more of us have the "one-click" option to order tests and treatments." Reputations are made and book sells are created by challenging current practice no matter how ludicrous the challenge is.

To assert that the standards of quality metrics come from the quality metrics themselves is to ignore science. The standard of 7% for hemoglobin A1C to judge the quality of diabetes care was not established by the defining of a quality metric; it was defined by science. That science is not absolute. Some argue for 6.5%, others are examining whether the standard can be stratified by age and/or by the duration of a patient having had diabetes. The quality metric will change as our knowledge expands, but the metric and the threshold was not established as a capricious effort to make someone sick who has a benign, inconsequential condition that doesn't matter. While the 999, in Dr. Welch's paradigm, may decide that they do not care about the 78 who have diabetes and the 20+ who don't know they have diabetes, or while Dr. Welch may argue that the 999 shouldn't care, the good news is that our society does care and our hope is that they will continue to care.

To argue that electronic medical records (EMR) are adding to the problem because they make compliance with quality metrics easier is to ignore the patient safety and quality of care advancements which have been made possible by the use of EMRs. The problem for Dr. Welch's theories is the same as the problem for healthcare providers, the explosion of knowledge – sound, scientific, valid science – which enable us to do more to help people manage their own health than ever before in medicine. Can EMRs be abused? Absolutely, but their potential for good far outweigh that potential.

Dr. Welch has uncovered a problem in healthcare but unfortunately he has drawn the wrong conclusions and offered the wrong solutions. Advancement in healthcare, particularly in preventive care, screening care and disease management will, in the short run, increase cost. Fortunately, in the long run, they will decrease cost. Diagnosing and treating people with diabetes will increase the cost of their care, but done excellently it will prevent blindness, amputations, coronary bypass surgeries, dialysis and other expensive treatments for complications of the neglect of the treatment of diabetes. None of this addresses the value to the individual, which in our value system and culture is paramount, as it is not the collective which only has value, but each individual, no matter how poor, no matter how old, no matter how powerless – you name the "no matter…" – has absolute value as a human being.

We must control the cost of care but it is not by ignoring science, it must be done by applying science. We must stop paying for treatments which have no scientific bases, no matter how good that treatment makes a person feel. We must eliminate waste by monitoring excessive use of expensive treatment and diagnostic tests which do not add to the health of a patient. Patients must be involved in their healthcare decision making. It is OK for a patient to decide they don't want a type of care even if it is scientifically sound, but that decision is the patient's in collaboration with his/her healthcare provider, not Dr. Welch's. In collaboration with the patient, the patient and healthcare provider must rationally decide when it is time to stop testing and treating and face the fact that the highest good in life is not the indefinite and impossible preservation of a heart beat or a respiration. End of life decisions will have to be made by the healthcare team, compassionately, rationally but appropriately.

In 1985, a pediatrician published an article in which he argued that there are instances where a pig has more value than a human child who is infirmed. I oppose that idea with everything I believe and practice. The implications of Dr. Welch's ideas, I believe, derived from the same philosophy and will lead to the same conclusions. I oppose his ideas. I am sure he is a caring and competent physician but the implications of his ideas are either not obvious to him or intend to pursue an agenda which has little to do with healthcare and science.

Can More Care Provide Less Health?
By James L. Holly, MD
Your Life Your Health
The Examiner
May 14, 2009

May 11, 2009, Parija B. Kavilanz, CNNMoney.com senior writer, summarized news reports about President Obama's efforts to get stakeholders in healthcare to agree to cut cost. His report in part stated:

> "Advocating preventive care and streamlining administrative costs are among the steps being promised by the health care industry to help cut $2 trillion in health care expenses over the next decade.
>
> "'What's brought us all together today is a recognition that we can't continue down the same dangerous road we've been traveling for so many years, that [health care] costs are out of control, and that reform is not a luxury that can be postponed, but a necessity that cannot wait,' Obama said at a White House event with representatives of the trade groups.
>
> "Among the groups, the Service Employees International Union (SEIU), which represents 110,000 nurses and 40,000 doctors…'(is) committed to creating a new American healthcare system by increasing efficiency of care without sacrificing quality of care, and creating a system of wellness, where we now have a system of illness…'"

On Monday, I responded to this reporter and said:

> "I read your story about healthcare savings with interest. I am the CEO of a medium size multi-specialty practice which provides care to the neediest of our community. We are actively remodeling our practice to reflect the vision of Medical Home and its extension into a Medical Neighborhood.
>
> "Our practice measures each clinic visit by multiple evidence-based quality indicators: HEDIS, NCQA, NQF, PQRI and Physician Consortium for Performance Improvement. In July, we will begin publicly reporting our performance on these measurement sets.
>
> "One of the hopes which the President voices is that preventive care will reduce the cost of care without reducing the quality. In the long run that will happen. In the short run, it will not. Successful deployment of preventive and evidenced-based measures may begin showing improvement in ten years, probably not before.
>
> "For instance, preventive immunizations a year for the neediest of our patients will cost $320,000 just to buy the shots, not including any administrative fee. That's one practice with one relatively small population. That's the cost of three shots per

patient the first year. That does not include the cost of mammograms, colonoscopies, bone densities, etc.

"The best way to reduce costs in the long run is with evidenced-based medicine. Medical and Surgical specialty societies' standards of care often reflect the welfare of their constituencies. The ONLY check and balance between quality and cost is evidenced-based medicine. And, the ONLY way to successfully deal with the cost of healthcare is to intervene at the point of care when what '**can be do**' is confronted by what '**should be done**.'

"The President cannot reform healthcare just by controlling cost and squeezing physicians. Utilization must be controlled but without rationing. More and more utilization is driven by patient demand. The majority of excessive cost in Medicare can be eliminated by the effective and appropriate management of end-of-life issues and the elimination of the ineffective and unsuccessful care which is given in the last 90 days of life."

The July 1, 2008 *Consumer Reports* contained an article entitled, "Too much treatment? Aggressive medical care can lead to more pain, with no gain." The following was reported:

> "For many consumers and their doctors, good health care means seeing as many specialists as you want. It means undergoing rounds of diagnostic tests, such as CT scans, to make sure everything is going well. And when you're seriously ill, it means prolonged hospital stays and every conceivable treatment.
>
> "Though the idea that more health care is better seems to make intuitive sense, recent research has shown that none of the above necessarily helps you live better or longer. In fact, too much medical care might shorten your life.
>
> "Those findings grew out of the 2008 Dartmouth Atlas of Health Care study and almost three decades of research by John E. Wennberg, M.D., and colleagues at Dartmouth Medical School (available at www.dartmouthatlas.org). Their 2008 Atlas study of 4,732,448 Medicare patients at thousands of hospitals in the U.S. from 2001 through 2005 found tremendous variation in the way people with serious illnesses such as heart failure and cancer were treated during the last two years of their lives. Some regions used two or three times the medical and financial resources than others."

Consumer Reports summarized the most dramatic findings of the Dartmouth study:

> "…patients with serious conditions who are treated in regions that provide the most aggressive medical care—have the most tests and procedures, see the most specialists, and spend the most days in hospitals—don't live longer or enjoy a better quality of life than those who receive more conservative treatment.

Patients treated most aggressively are at increased risk of infections and medical errors that come from uncoordinated care (such as two doctors prescribing the same drug or clashing ones). They also receive poorer-quality care, spend a lot more money on co-pays, and are least satisfied with their health care, the Dartmouth research has found.

The Dartmouth study by John E. Wennberg, M.D., and Elliott S. Fisher, M.D., found that extra care didn't lead to better results."

Consumer Reports continued:

"The amount of medical care that people get for serious illnesses varies enormously from place to place. In the last two years of life, the average patient spent 11 days in the hospital in Bend, Ore., and 35 days in Manhattan. In those same two years, patients visited the doctor an average of 34 times in Ogden, Utah, and 109 times in Los Angeles.

"The Dartmouth Atlas based those findings on Medicare claims records of millions of patients who died from (in order of prevalence) congestive heart failure, chronic pulmonary (lung) disease, cancer, dementia, coronary artery disease, chronic kidney failure, peripheral vascular (circulatory) disease, diabetes with organ damage, and severe chronic liver disease. Together those ailments account for about 90 percent of deaths of people older than 65.

"Over the years, Dartmouth research has yielded some startling insights:

- The local supply of doctors and hospitals has more influence on the amount and type of care that patients receive than their actual medical conditions have. The more medical resources a region has, the more aggressive the treatments are.
- In the regions that deliver the most care, patients have a slightly higher death rate than patients with the same conditions treated in areas that treat less aggressively.
- Patients treated most aggressively are no more satisfied with their care.
- The cost differences are vast. Average Medicare spending over the last two years of life for all hospitals ranged from a high of $181,143 in Manhattan to a low of $29,116 in Dubuque, Iowa.

"A key question, of course, is whether patients are being kept alive longer in the regions that spend more money and deliver more aggressive care. To judge survival, you have to look at people who are similarly ill and then follow them forward over time,' says Elliott S. Fisher, M.D., Wennberg's longtime research collaborator. 'And we've done that.' Their study of 969,325 Medicare beneficiaries hospitalized nationwide for three common conditions—colon cancer, heart attack, and hip fracture—published in the Feb. 18, 2003, issue of the *Annals of Internal Medicine*, analyzed the follow-up tests and treatments the patients received for up to five years after their very similar initial treatment.

> “Patients in the highest-spending areas received 60 percent more treatment than those in the lowest-spending areas, but the extra care didn't seem to help at all, and it made some things worse. Patients in the high-spending, aggressive-care regions waited longer in emergency rooms and doctors' offices than patients in lower-spending regions did. They were less likely to get recommended preventive treatments, such as aspirin to prevent future heart attacks, or appropriate immunizations. They were slightly more likely to die, and those who didn't die weren't any better off in terms of their ability to function in daily life. And overall they were no more satisfied with their care.”

Like Medical Home, Primary Care is seen as the answer

> "’We see huge regional differences in health-care quality,’ says IBM's Grundy, whose department buys health insurance for 386,000 employees around the world. There's almost an inverse relationship between cost and quality, with the better quality in the states with a high concentration of primary-care providers,’ he says. ‘Primary-care doctors are trained to manage the ‘whole person,’ which can help keep seriously ill people doing well and out of the hospital.
>
> “’Seeing too many specialists produces ‘fragmentation,’ says Donald M. Berwick, M.D., president and CEO of the Institute for Healthcare Improvement, a not-for-profit organization based in Cambridge, Mass. ‘If you have 18 doctors, you'll have more coordination problems than if you have three.’”

What Have We Learned?

The last thing any of us wants is a healthcare system in which a patient is denied certain care based on age. In reality, there are some 80-year-old patients who should have a coronary by-pass and there are some 50-year-olds who should not. In addition, just because we can do something does not mean that it is appropriate to do it.

Often the most loving thing which can do for a parent, a spouse, or for other loved ones is to say “no,” to tests, procedures, or invasive care. The ONLY consideration in healthcare decisions should be the welfare of the patient and often that welfare is best defined by what you choose not to do rather than by what you do.

What Should We Do?

- Encourage primary care. Fewer medical-school graduates are going into primary care because they can make much more money as specialists, no small consideration when faced with paying off six-figure student loans. Medicare is currently studying paying primary-care doctors extra for functioning as a "medical home" for patients, helping to manage their chronic ailments and coordinating care provided by specialists.
- Find out what really works. The government should fund more research comparing different treatments for common conditions, and then scale reimbursements to encourage

the use of the most effective care. That would help discourage the unnecessary treatments and tests found in high-spending regions.

- Think twice about drastic measures. More aggressive hospitals more often use treatments such as feeding tubes and cardiopulmonary resuscitation in patients nearing death. But those measures might not extend life for long, if at all, and can be uncomfortable.
- Every adult should have an "advance directive" (available at www.caringinfo.org). It gives your preferences for care in the event you are ill with no prospect of recovery and unable to express your wishes.
- Consider hospice care for a patient who, in the opinion of doctors, is likely to die within six months. Studies show that patients receiving hospice care on average live slightly longer than those with the same illnesses who are not in hospice.
- Don't be pressured into agreeing to invasive life-support treatments, such as feeding tubes, without a thorough discussion of the patient's prognosis, personal preferences (if known), and overall condition.

Healthcare reform is a complicated issue with many parties having their own agenda. As healthcare providers, we must continue to advocate for our patients, but that advocacy must not be just to keep doing more, when doing less may be the compassionate, human and right thing to do.

Care Transitions: The Heart of Patient-Centered Medical Home
A Summary of SETMA's fourteen-year pilgrimage toward a quality initiative to decrease preventable readmissions to the Hospital
James L. Holly M.D.
May 24, 2011
Scottsdale Institute Webinar

This May, 2011 presentation addresses SETMA's 14-year development of the functions which allow us to do effective transitions of care. This is a brief summary of a presentation of the same title which has been given at multiple sites in 2011.

Care Transitions: The heart of Patient-Center Medical Home

Scottsdale Institute Webinar
May 24, 2011
Dr. James L. Holly, CEO
Southeast Texas Medical Associates, LLP
www.jameslhollymd.com

Care Transitions

In SETMA's Model of Care **-- Care Transition** involves:

1. **Evaluation at admission** **--** transition issues : "lives alone," barriers , DME, residential care, or other needs
2. **Fulfillment of PCPI Transitions of Care Quality Metric Set**
3. **Post Hospital Follow-up Coaching --** a 12-30 minute call made by members of SETMA's Care Coordination Department and additional support
4. **Plan of Care and Treatment Plan**
5. **Follow-up visit with primary provider**

National Priorities Partnership

National Priorities Partnership
National Quality Forum
Input to the Secretary of HHS
Priorities for the 2011 National Quality Strategy

- Wellness and Prevention
- Safety
- Patient and Family Engagement
- Care Coordination
- Palliative and End of Life Care

National Priorities Partnership

Addressing the fourth NPP goal, the NQF report to HHS stated that in regard to care coordination:

"Healthcare should guide patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships among patients and the healthcare professionals accountable for their care…."

National Priorities Partnership

Focus in care coordination by NPP are the links between:

Care Transitions— …continually strive to improve care by … considering feedback from all patients and their families… regarding coordination of their care during transitions between healthcare systems and services, and…communities.

Preventable Readmissions— …work collaboratively with patients to reduce preventable 30-day readmission rates.

Care Transitions & Hospital Readmission

In SETMA's experience, there are fifteen steps required to address care coordination and hospital readmissions, as a function of a quality care initiative which is sustainable.

The steps and the solution for each are as follows.

Care Transitions & Hospital Readmission

1. In January,1999, SETMA began using the EHR to document patient encounters. In May, 1999, SETMA modified the goal to **electronic patient management** (EPM) in order to leverage the power of electronics to improve treatment outcomes. In October, SETMA began using the EMR in the hospital for **hospital H&Ps**, creating continuity-of-care process, based on healthcare data being electronically created and being available at all points of care.

Care Transitions & Hospital Readmission

2. In 2000, realizing that excellent care in the 21st Century was going to be team-based, SETMA formed a **hospital service team,** which provides 24-hour-a-day, seven-day a week, in-house coverage for all of our patients.

Care Transitions & Hospital Readmission

3. In 2001, SETMA began using the EHR to produce hospital **discharge summaries** which further advanced continuity-of-patient-care and established the groundwork both for care transitions and for effectively addressing preventable readmissions.

   At this point, **medication reconciliation** could take place in the: clinic, hospital, nursing home, home health and emergency department.

Care Transitions & Hospital Readmission

4. In 2003, SETMA designed **hospital-admission-order sets**, based on national standards of care, which created a consistency of treatment plans and eliminated delay in the initiation of excellent care.

Care Transitions & Hospital Readmission

5. Also ,in 2003, SETMA began using the EHR in all **twenty-two nursing homes** we staff. Because our patients' care is managed in the same electronic data base, whether in the ambulatory setting, hospice, home health, physical therapy, hospital, emergency department, or nursing home, there is a continuity-of-care which is data and information driven.

Care Transitions & Hospital Readmission

6. In 2004, SETMA designed an electronic, **Inpatient Medical Record Census** (IMRC); deployed on SETMA's intranet and HIPPA compliant, the IMRC allows searchable-data recording of:

   a. date of admission to the hospital
   b. place of admission
   c. date and time of completion of the History and Physical
   d. date of discharge
   e. date and time of completion of the **Hospital Care summary and post-hospital plan of care and treatment plan**.
   f. Posting of questions from business office which need research by hospital care team.

Care Transitions & Hospital Readmission

7. In 2007, SETMA's partners realized that many of our patients, even those with insurance, cannot afford all of their health care. This resulted in the creation of **The SETMA Foundation**.

   SETMA partners have given over $1,500,000 to the Foundation which pays for medications, surgeries and other care, such as dental, for our patients who cannot afford it.

Care Transitions & Hospital Readmission

8. In June, 2009, the **Physician Consortium for Performance Improvement (PCPI)** published the first national quality measurement set on **Care Transitions**; the same month, SETMA deployed the measures in our EHR. Since then, of the 2995 discharges from the hospital, 99.1% have had the Hospital Care Summary completed at the time the patient left the hospital.

Care Transitions & Hospital Readmission

9. October, 2009, SETMA adapted a **Business Intelligence tool to create an audit** of hospitalized patients to examine differences between patients who are re-admitted and those who are not. The audit looks at: gender, ethnicity, socio-economic issues, social isolation, morbidities and co-morbidities, lengths of stays, age, timing of follow-up after discharge, whether a follow-up call was received and other issues. T**hese measures look for leverage points for "making a change, which will make a difference in readmissions"**

Care Transitions & Hospital Readmission

10. November, 2009, SETMA began **publicly reporting performance** on over 200 quality metrics **by provider name** at www.jameslhollymd.com. management plans-of-care documents for diabetes, hypertension, and cholesterol, include the provider performance on that patient's care, as judged by these quality metrics.

Care Transitions & Hospital Readmission..

11. In July, 2010, pursuant to becoming a Tier 3 PC-MH, SETMA created a **Department of Care Coordination**, which is tasked with:

- Post Hospital follow-up calling
- Completing SETMA Foundation Referrals
- Patient counseling for barriers to care
- Establishing continuity of care
- Engaging patients in their own care
- Alerting providers to patients' special needs
- Another level of mediation reconciliation

Care Transitions & Hospital Readmission"

12. September, 2010, at a National Quality Forum workshop on Care Transitions, SETMA realized that the term "discharge summary" was outdated. We changed the name to "**Hospital Care Summary and Post Hospital Plan-of-Care and Treatment-Plan**," long and perhaps awkward, this name, is functional, focusing on the unique elements of Care Transition which contribute to the foundation for a sustainable plan for addressing preventable readmissions to the hospital.

Care Transitions & Hospital Readmission

13. In 2010, SETMA deployed both a **secure web portal** and a **health information exchange** to allow the seamless exchange of information between the hospitals , nursing homes, home health agencies, hospices, and SETMA. The HIE has been expanded to a seven-county project including all healthcare providers and agencies, which will ultimately be the key to preventing readmission to the hospital.

Care Transitions & Hospital Readmission

14. Since 1997, SETMA has partnered with a **Medicare Advantage home health** agency, with other home health agencies and with **free-standing hospices** to provide compassionate, competent care for our patients in settings other than hospital inpatient to reduce readmissions of our most vulnerable patients while providing excellent care to them.

Care Transitions & Hospital Readmission

15. As a **Patient-Centered Medical Home**, SETMA makes certain that the Hospital Care Summary and Post Hospital Plan of Care and Treatment is transmitted to the next site of care as the "baton," (see below). **With these care coordination, continuity of care and patient-support functions, SETMA believes that we are ready to make a major effort to decrease preventable readmissions to the hospital.**

Care Transitions & Hospital Readmission

These tools and functions have allowed sustainable improvements. For example:

- In February, 2011, during one weekend, SETMA discharged 26 patients in two days.
- Most of these discharges were challenging, but all were treated all through SETMA's standard procedures and processes described above.
- Over the next 60 days, 6.8% were readmitted.

CARE TRANSITIONS

In SETMA's Model of Care **-- Care Transition** involves:

1. **Evaluation at admission --** transition issues: "lives alone," barriers , DME, residential care, or other needs
2. **Fulfillment of PCPI Transitions of Care Quality Metric Set**
3. **Post Hospital Follow-up Coaching --** a 12-30 minute call made by members of SETMA's Care Coordination Department and additional support
4. **Plan of Care and Treatment Plan**
5. **Follow-up visit with primary provider**

Hospital Care Summary

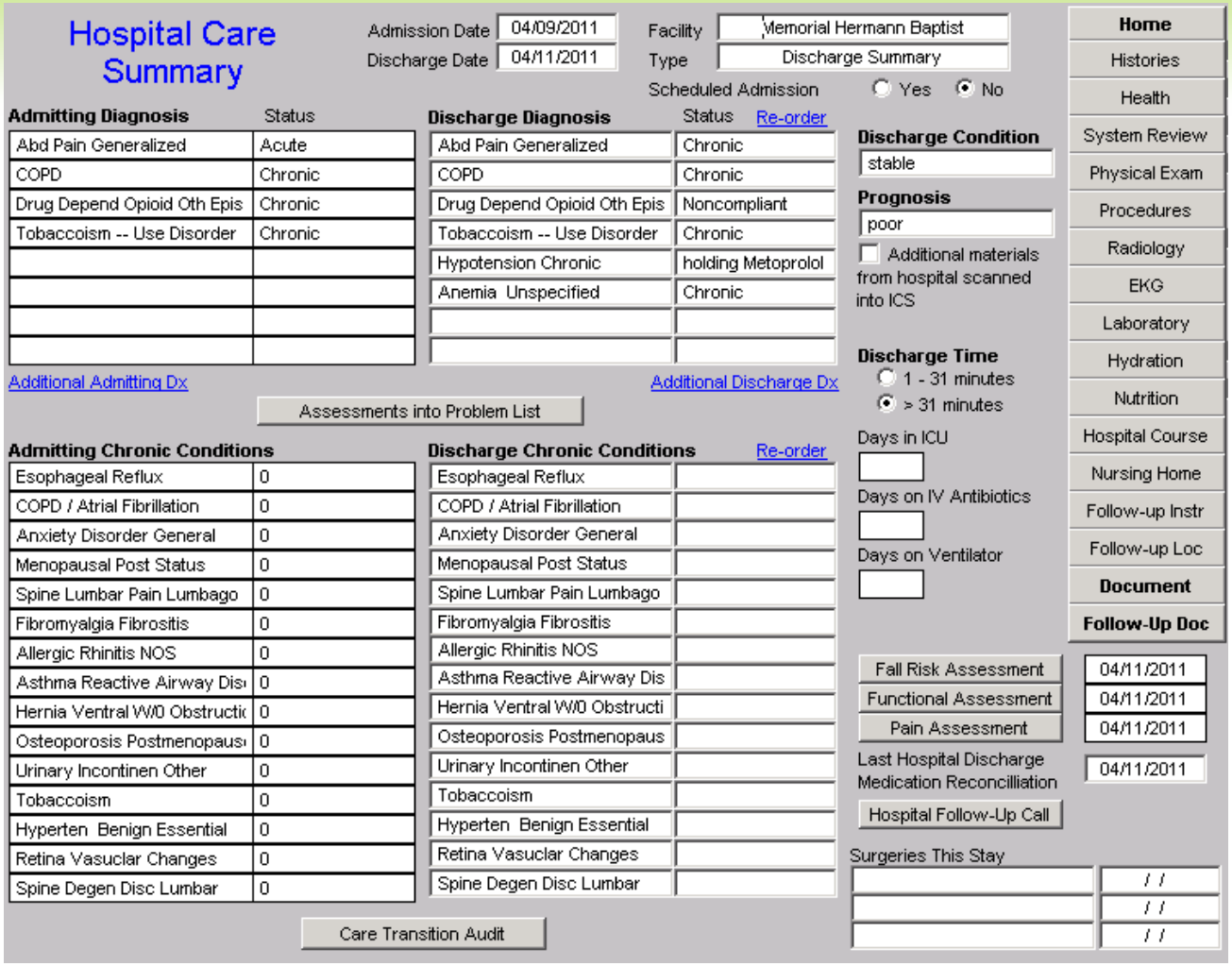
SETMA's Hospital Care Summary is a suite of templates with which the transition of care document Is created. (A full tutorial of these templates can be found on our website at www.jameslhollymd.com under "**Electronic Patient Tools**" at "**Hospital Based Tools**.")

The following is a screen shot of the Master Discharge Template entitled "**Hospital Care Summary**". This screen shot is from the record of a real patient whose

Hospital Care Summary

identify has been removed.

HOSPITAL CARE SUMMARY



Hospital Care Summary

Admission Date 04/09/2011
Discharge Date 04/11/2011
Facility Memorial Hermann Baptist
Type Discharge Summary
Scheduled Admission ○ Yes ◉ No

Admitting Diagnosis	Status
Abd Pain Generalized	Acute
COPD	Chronic
Drug Depend Opioid Oth Epis	Chronic
Tobaccoism -- Use Disorder	Chronic

Additional Admitting Dx

Discharge Diagnosis	Status (Re-order)
Abd Pain Generalized	Chronic
COPD	Chronic
Drug Depend Opioid Oth Epis	Noncompliant
Tobaccoism -- Use Disorder	Chronic
Hypotension Chronic	holding Metoprolol
Anemia Unspecified	Chronic

Additional Discharge Dx

Assessments into Problem List

Admitting Chronic Conditions	
Esophageal Reflux	0
COPD / Atrial Fibrillation	0
Anxiety Disorder General	0
Menopausal Post Status	0
Spine Lumbar Pain Lumbago	0
Fibromyalgia Fibrositis	0
Allergic Rhinitis NOS	0
Asthma Reactive Airway Dis	0
Hernia Ventral W/0 Obstructi	0
Osteoporosis Postmenopaus	0
Urinary Incontinen Other	0
Tobaccoism	0
Hyperten Benign Essential	0
Retina Vasuclar Changes	0
Spine Degen Disc Lumbar	0

Discharge Chronic Conditions (Re-order)	
Esophageal Reflux	
COPD / Atrial Fibrillation	
Anxiety Disorder General	
Menopausal Post Status	
Spine Lumbar Pain Lumbago	
Fibromyalgia Fibrositis	
Allergic Rhinitis NOS	
Asthma Reactive Airway Dis	
Hernia Ventral W/0 Obstructi	
Osteoporosis Postmenopaus	
Urinary Incontinen Other	
Tobaccoism	
Hyperten Benign Essential	
Retina Vasuclar Changes	
Spine Degen Disc Lumbar	

Care Transition Audit

Discharge Condition: stable

Prognosis: poor

☐ Additional materials from hospital scanned into ICS

Discharge Time
○ 1 - 31 minutes
◉ > 31 minutes

Days in ICU
Days on IV Antibiotics
Days on Ventilator

Fall Risk Assessment 04/11/2011
Functional Assessment 04/11/2011
Pain Assessment 04/11/2011
Last Hospital Discharge Medication Reconcilliation 04/11/2011
Hospital Follow-Up Call

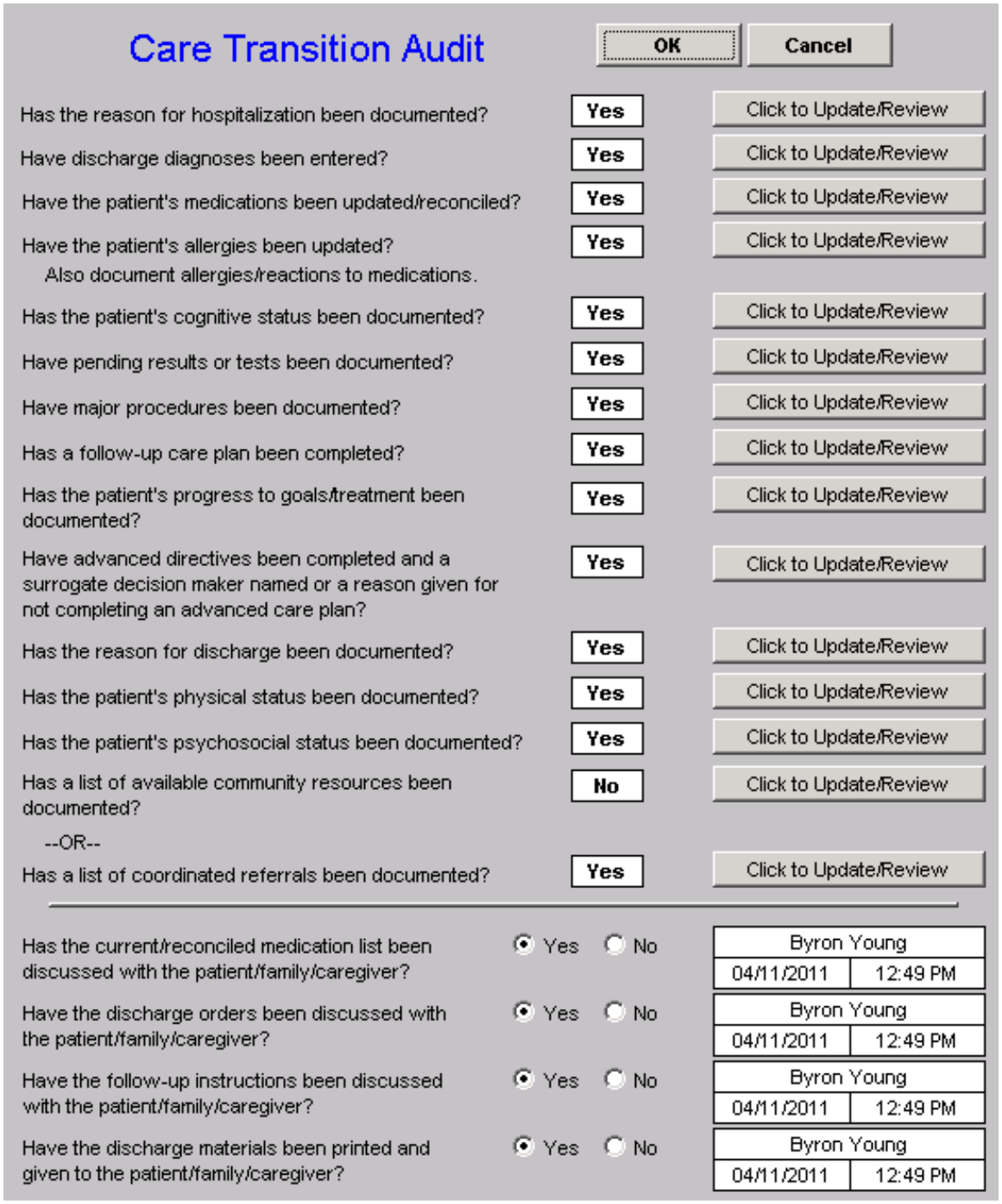
Surgeries This Stay

	/ /
	/ /
	/ /

Home
Histories
Health
System Review
Physical Exam
Procedures
Radiology
EKG
Laboratory
Hydration
Nutrition
Hospital Course
Nursing Home
Follow-up Instr
Follow-up Loc
Document
Follow-Up Doc

Care Transition Audit

At the bottom of this template, there is a button Entitled "**Care Transitions Audit**." Once the suite of Templates associated with the Hospital Care Summary has been completed, the provider depresses this button and the system automatically aggregates the data which has been documented and displays which of the 18-data points have been completed and which have not.


Care Transition Audit
OK
Cancel
Has the reason for hospitalization been documented?
Yes
Click to Update/Review
Have discharge diagnoses been entered?
Yes
Click to Update/Review
Have the patient's medications been updated/reconciled?
Yes
Click to Update/Review
Have the patient's allergies been updated?
Also document allergies/reactions to medications.
Yes
Click to Update/Review
Has the patient's cognitive status been documented?
Yes
Click to Update/Review
Have pending results or tests been documented?
Yes
Click to Update/Review
Have major procedures been documented?
Yes
Click to Update/Review
Has a follow-up care plan been completed?
Yes
Click to Update/Review
Has the patient's progress to goals/treatment been documented?
Yes
Click to Update/Review
Have advanced directives been completed and a surrogate decision maker named or a reason given for not completing an advanced care plan?
Yes
Click to Update/Review
Has the reason for discharge been documented?
Yes
Click to Update/Review
Has the patient's physical status been documented?
Yes
Click to Update/Review
Has the patient's psychosocial status been documented?
Yes
Click to Update/Review
Has a list of available community resources been documented?
No
Click to Update/Review
--OR--
Has a list of coordinated referrals been documented?
Yes
Click to Update/Review
Has the current/reconciled medication list been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge orders been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the follow-up instructions been discussed with the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM
Have the discharge materials been printed and given to the patient/family/caregiver?
Yes
No
Byron Young
04/11/2011
12:49 PM

Care Transition Audit

The elements in black have been completed; any in red have not. If an element is incomplete, the provider simply clicks the button entitled “Click to update/Review.” The missing information can then be added. This fulfills one of SETMA’s principles of EHR design which is “**We want to make it easier to do it right than not to do it at all**.”

Care Transition Audit

Quarterly and annually, SETMA audits each provider's performance on these measures and publishes that audit on our website under "**Public Reporting**," along with over 200 other quality metrics which we track routinely.

The following is the care transition audit results by provider name for 2010.

Care Transition Audit

Care Transition Audit (Section A)

Discharge Date(s): 01/01/2010 through 12/31/2010

Provider	Reason for Hospitalization	Discharge Diagnoses	Medications Updated Reconciled	Documentation of Allergies	Cognitive Status	Pending Test Results	Major Procedures	Follow-Up Care Plan	Progress to Goals Response to Treatment
Ahmed	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Anwar	95.0%	100.0%	82.4%	88.9%	93.5%	92.9%	90.7%	93.7%	95.0%
Aziz	98.4%	100.0%	95.2%	94.7%	96.7%	98.2%	95.6%	97.2%	95.6%
Colbert	100.0%	100.0%	50.0%	50.0%	83.3%	100.0%	66.7%	100.0%	100.0%
Cricchio	91.7%	94.4%	94.4%	91.7%	94.4%	91.7%	88.9%	88.9%	91.7%
Curry	99.1%	100.0%	97.2%	95.3%	96.2%	100.0%	95.3%	98.1%	98.1%
Deiparine	97.7%	100.0%	90.0%	95.8%	97.2%	96.3%	95.6%	96.3%	97.4%
Groff	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	98.2%	99.5%	94.1%	95.0%	95.9%	98.2%	94.1%	95.4%	96.3%
Henderson	84.0%	100.0%	64.0%	96.0%	96.0%	96.0%	88.0%	92.0%	92.0%
Holly	94.2%	99.7%	87.3%	94.0%	96.8%	91.8%	91.2%	91.3%	93.9%
Leifeste	97.6%	100.0%	88.0%	95.3%	98.6%	95.5%	95.9%	96.6%	96.4%
Murphy	98.7%	99.6%	95.7%	94.5%	95.3%	98.7%	95.3%	97.9%	94.5%
Qureshi	90.4%	100.0%	84.6%	96.2%	98.1%	90.4%	92.3%	94.2%	88.5%
Satterwhite	98.3%	100.0%	90.4%	90.4%	94.8%	99.1%	93.9%	93.0%	98.3%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	97.3%	99.7%	87.2%	93.9%	96.5%	95.5%	97.1%	95.2%	97.1%
Vardiman	96.9%	100.0%	88.8%	91.8%	96.9%	98.0%	93.9%	98.0%	95.9%
Young	86.8%	100.0%	73.6%	88.7%	86.8%	86.8%	86.8%	83.0%	86.8%
SETMA Totals :	96.4%	99.8%	89.1%	93.8%	96.4%	95.1%	93.7%	94.6%	95.4%

Care Transition Audit

Care Transition Audit (Section B)

Discharge Date(s): 01/01/2010 through 12/31/2010

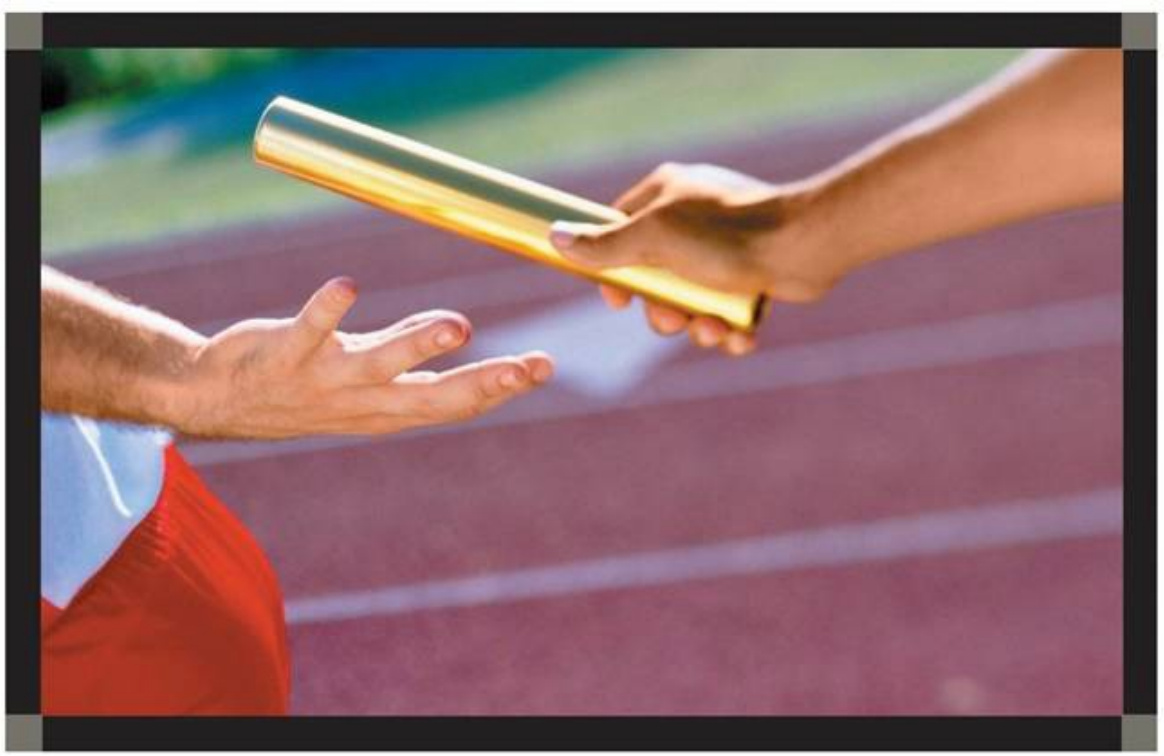
Provider	Advanced Directives	Reason for Discharge	Physical Status	Psychosocial Status	Community Resources Coordinated Referrals	Medication List	Discharge Orders	Follow-Up Instructions	Discharge Materials
Ahmed	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
Anwar	76.1%	95.2%	94.5%	88.7%	68.5%	77.6%	78.3%	78.3%	78.1%
Aziz	88.5%	97.9%	97.2%	93.9%	33.8%	83.7%	83.7%	83.5%	83.2%
Colbert	50.0%	100.0%	83.3%	50.0%	33.3%	50.0%	50.0%	50.0%	50.0%
Cricchio	36.1%	91.7%	97.2%	86.1%	8.3%	86.1%	86.1%	86.1%	86.1%
Curry	88.7%	100.0%	96.2%	96.2%	48.1%	85.8%	85.8%	85.8%	85.8%
Deiparine	85.6%	97.4%	97.2%	93.7%	77.3%	84.7%	84.7%	84.7%	84.5%
Groff	66.7%	100.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%
Gulfcoast	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Halbert	88.6%	98.2%	95.9%	93.6%	47.9%	81.3%	81.7%	81.7%	81.7%
Henderson	24.0%	92.0%	96.0%	92.0%	44.0%	56.0%	56.0%	56.0%	56.0%
Holly	81.8%	93.2%	97.3%	91.8%	76.9%	80.7%	80.8%	80.7%	80.6%
Leifeste	85.2%	96.4%	98.6%	93.1%	69.4%	84.4%	84.4%	84.4%	83.8%
Murphy	88.5%	97.9%	96.6%	95.7%	53.2%	87.2%	87.2%	87.2%	87.2%
Qureshi	84.6%	90.4%	98.1%	96.2%	76.9%	82.7%	82.7%	82.7%	82.7%
Satterwhite	69.6%	98.3%	95.7%	90.4%	43.5%	69.6%	69.6%	69.6%	68.7%
Spiel	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Thomas	84.8%	96.0%	97.1%	93.4%	73.4%	83.2%	83.5%	83.5%	83.2%
Vardiman	74.5%	98.0%	96.9%	91.8%	62.2%	79.6%	78.6%	78.6%	78.6%
Young	67.9%	83.0%	86.8%	84.9%	30.2%	69.8%	69.8%	69.8%	69.8%
SETMA Totals :	82.7%	95.8%	96.8%	92.5%	63.2%	81.8%	81.9%	81.9%	81.7%

Hospital Care Summary

Once the **Care Transition** issues are completed, The **Hospital Care-Summary-and-Post- Hospital-Plan-of Care-and Treatment-Plan** document is generated and printed. It is given to the patient and/or to the patient's family, and to the hospital.

The Baton

The following picture is a portrayal of the "plan of care and treatment plan" which is like the "baton" in a relay race.



The Baton

"The Baton" is the instrument through which responsibility for a patient's health care is transferred to the patient or family. Framed copies of this picture hang in the public areas of all SETMA clinics and a poster of it hangs in every examination room. The poster declares:

Firmly in the provider's hand
--The baton -- the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The Baton

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the “baton,” is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the “baton,” which has been developed by the healthcare team, is a coordinated effort between the provider and the patient.

The Baton

4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but without its transfer to the patient, the provider's knowledge is useless to the patient.

5. That the imperative for the plan – the "baton" – is that it must be transferred from the provider to the patient, **if change in the life of the patient is going to make a difference in the patient's health.**

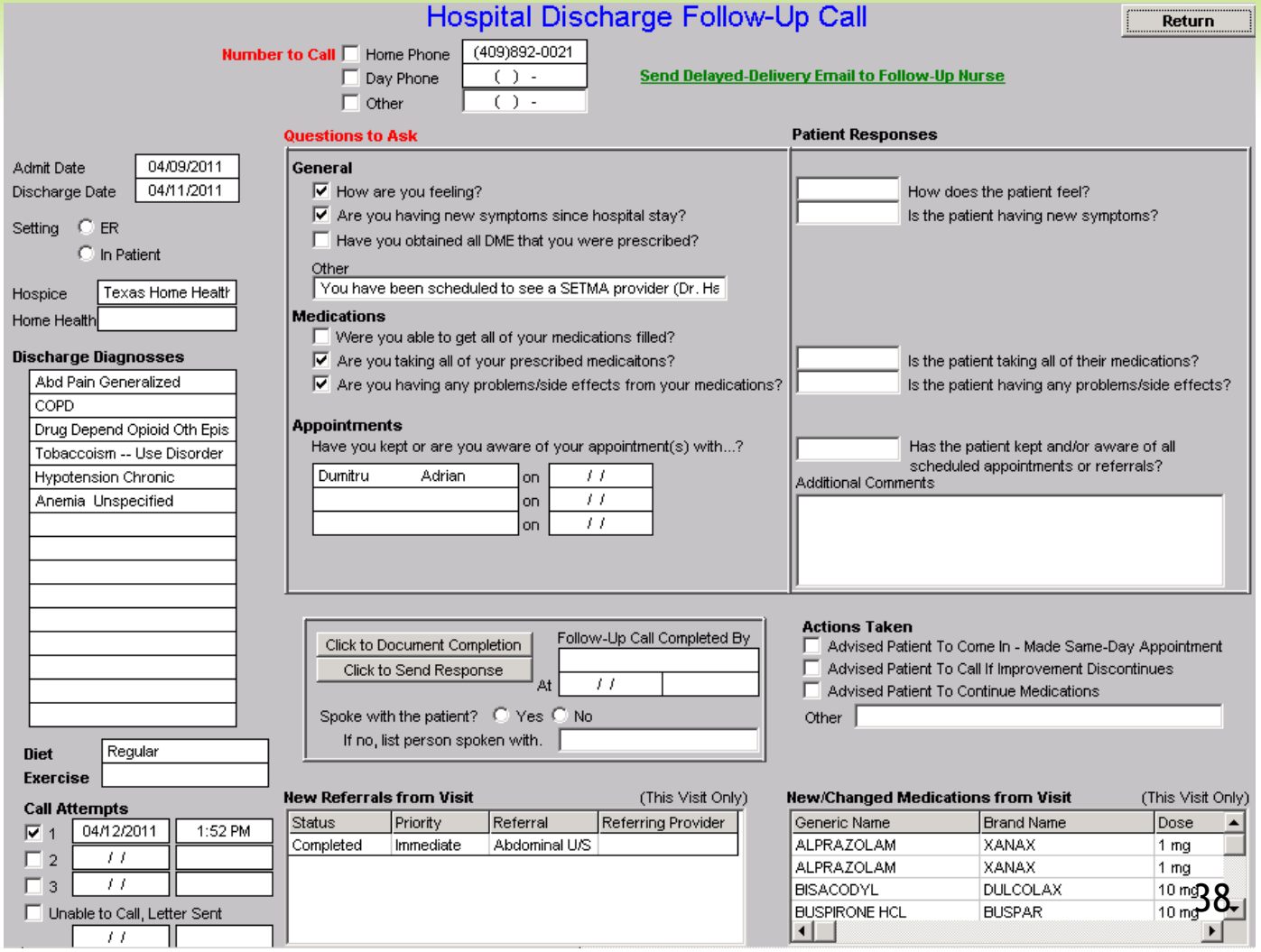
The Baton

6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient **accepts**, **receives**, **understands** and **comprehends** the plan, and that the patient is equipped and empowered to carry out the plan successfully.

7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

Hospital Follow-Up Call

After the care transition audit is completed and the document is generated, the provider completes the Hospital-Follow-up-Call document:



Hospital Discharge Follow-Up Call

Return

Number to Call: Home Phone (409)892-0021; Day Phone ( ) -; Other ( ) -

Send Delayed-Delivery Email to Follow-Up Nurse

Admit Date 04/09/2011
Discharge Date 04/11/2011

Setting: ER / In Patient

Hospice: Texas Home Health
Home Health:

Discharge Diagnoses

- Abd Pain Generalized
- COPD
- Drug Depend Opioid Oth Epis
- Tobaccoism -- Use Disorder
- Hypotension Chronic
- Anemia Unspecified

Diet: Regular
Exercise:

Call Attempts

1	04/12/2011	1:52 PM
2	/ /	
3	/ /	

Unable to Call, Letter Sent / /

Questions to Ask

General
- How are you feeling?
- Are you having new symptoms since hospital stay?
- Have you obtained all DME that you were prescribed?

Other: You have been scheduled to see a SETMA provider (Dr. Ha

Medications
- Were you able to get all of your medications filled?
- Are you taking all of your prescribed medicaitons?
- Are you having any problems/side effects from your medications?

Appointments

Have you kept or are you aware of your appointment(s) with...?

Dumitru	Adrian	on / /
		on / /
		on / /

Patient Responses

- How does the patient feel?
- Is the patient having new symptoms?
- Is the patient taking all of their medications?
- Is the patient having any problems/side effects?
- Has the patient kept and/or aware of all scheduled appointments or referrals?

Additional Comments

Click to Document Completion
Click to Send Response
Follow-Up Call Completed By
At / /

Spoke with the patient? Yes / No
If no, list person spoken with.

Actions Taken
- Advised Patient To Come In - Made Same-Day Appointment
- Advised Patient To Call If Improvement Discontinues
- Advised Patient To Continue Medications

Other

New Referrals from Visit (This Visit Only)

Status	Priority	Referral	Referring Provider
Completed	Immediate	Abdominal U/S	

New/Changed Medications from Visit (This Visit Only)

Generic Name	Brand Name	Dose
ALPRAZOLAM	XANAX	1 mg
ALPRAZOLAM	XANAX	1 mg
BISACODYL	DULCOLAX	10 mg
BUSPIRONE HCL	BUSPAR	10 mg

Follow-Up Call -- I

- During that preparation of the “baton,” the provider checks off the questions which are to be asked the patient in the follow-up call.
- The call order is sent to the Care Coordination Department electronically. The day following discharge, the patient is called.
- The call is the beginning of the “**coaching**” of the patient to help make them successful in the transition from the inpatient setting.

Follow-Up Call - II

- The Care-Coordination, post-hospital call takes 12-30 minutes with each patient and engages the patient in eliminating barriers to care.
- If appropriate, an additional call is scheduled at an appropriate interval.
- If after three attempts, the patient is not reached by phone, the box in the lower left-hand corner by "Unable to Call, Letter sent" is checked. Automatically, a letter is created which is sent to the patient asking them to contact SETMA.

Coordinated Care

The genius and the promise of the Patient-Centered Medical Home are symbolized by the "baton." Its display continually reminds the provider and will inform the patient, that to be successful, the patient's care must be **coordinated**, and must result in **coordinated care**.

In 2011, as we expand the scope of SETMA's Department of Care Coordination, we know that the principal failure-points of coordination are at the "transitions of care," and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute a plan which is effectively transmitted to the patient.

Transition of Care

The complexity of the Transition of Care process is illustrated by this analysis of the eight different places this document can need to be sent.

Hospital Care Summary

1. **Inpatient to ambulatory outpatient** (family) – The "baton," in a printed format, is given to the patient or in the case of a minor or incompetent adult to a parent or care giver.

   The "plan of care and treatment plan" -- "the baton" -- is reviewed with the patient, parent and/or family before the patient leaves the hospital.

Hospital Care Summary

2. **Inpatient to ambulatory outpatient** (clinic physician) – for patients who are seen at SETMA, the "baton" is created in the EHR and is immediately accessible to the follow-up provider.

Hospital Care Summary

3. **Inpatient to ambulatory outpatient** (follow-up call) -- after the **Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan** is completed, a secure e-mail is sent to the department of Care Coordination scheduling the post-hospital, follow-up call and letting the caller know the issues which need to be addressed.

Hospital Care Summary

4. **Emergency Department to ambulatory care** – the same process as in "1" above.
5. **Inpatient to Nursing Home** -- the "baton," with a special set of Nursing Home orders, is given to the patient or family, and a copy is sent to the Nursing Home with transportation of the patient to the Nursing home.
6. **Inpatient to Hospice** -- the same as with number “5“
7. **Inpatient to Home Health** -- the same as number "5“ and "6" above. If the patient is seeing SETMA's home health, they have access to SETMA EHR and thus to the "baton."

Hospital Care Summary

8. **Inpatient to outpatient out of area** -- "Baton" given to patient and family and also posted to web portal and HIE. token sent to health provider in remote location area, which allows one time access to this patient's information.

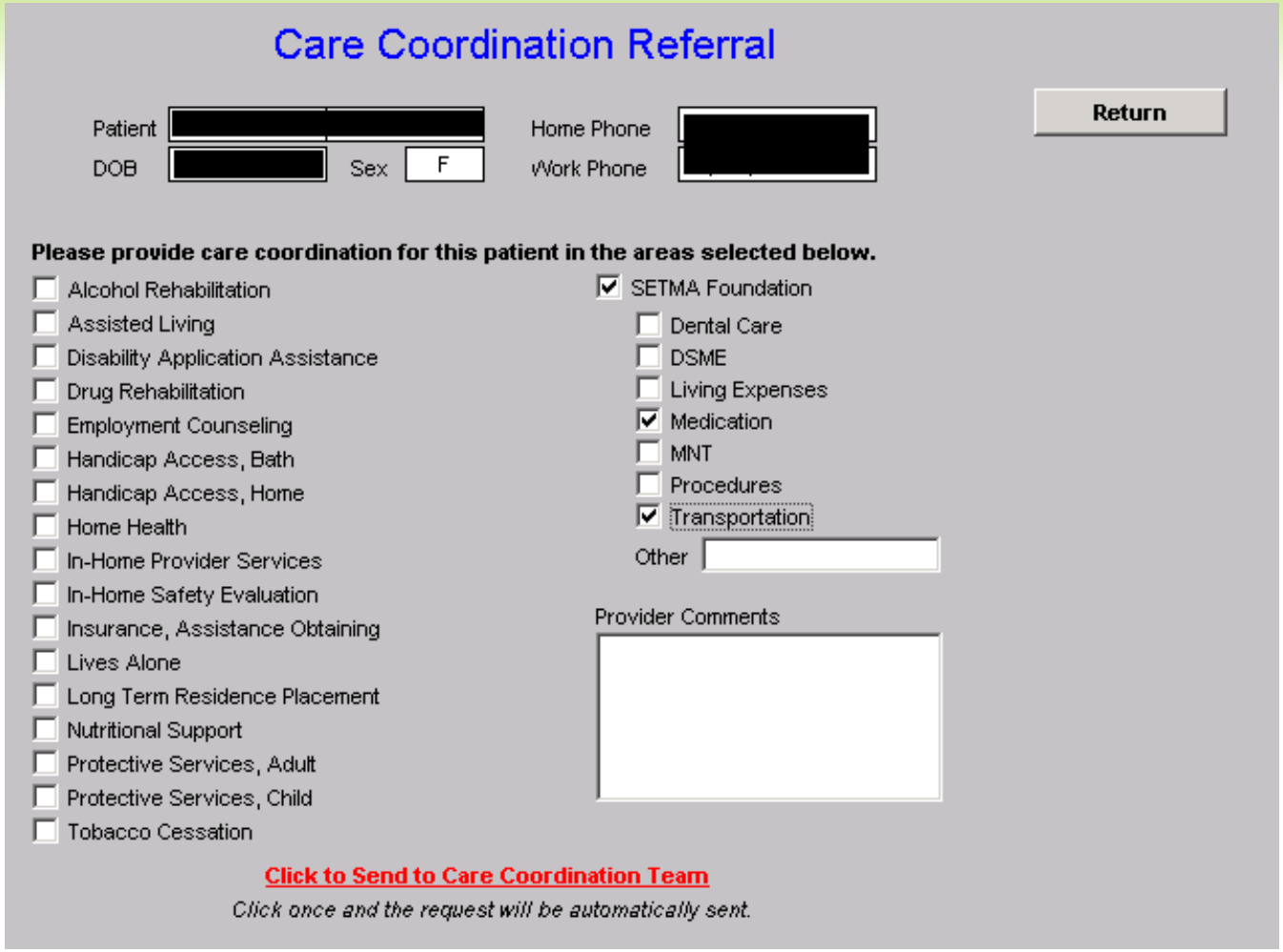
Follow-Up Visit

The Transition of Care is complete when the patent is seen by the primary care provider in follow-up.

- Many issues are dealt with in this follow-up visit, but one of them is another potential referral to the Care Coordination Department. If the patient has any barriers to care, the provider will complete the following template.

- In this case, with checking three buttons, the need for financial assistance with medications and transportation is communicated to the Care Coordination Department.

Care Coordination Referral



SETMA Foundation

Under the Medical Home model the provider has NOT done his/her job when he/she simply prescribes the care which meets national standards. **Doing the job of Medical Home requires the prescribing of the best care which is available and accessible to the patient, and when that care is less than the best, the provider makes every attempt to find resources to help that patient obtain the care needed**.

SETMA Foundation

In February 2009, SETMA saw a patient who has a very complex healthcare situation. When seen in the hospital as a new patient, he was angry, bitter and hostile. No amount of cajoling would change the patient's demeanor.

During his office-based, hospital follow-up, it was discovered that the patient was only taking four of nine medications because of expense; could not afford gas to come to the doctor; was going blind but did not have the money to see an eye specialist; could not afford the co-pays for diabetes education and could not work but did not know how to apply for disability.

SETMA Foundation

He left SETMA with the Foundation providing:

1. All of his medications. The Foundation has continued to do so for the past two years at a cost of $2,200 a quarter.
2. A gas card so that he could afford to come to multiple visits for education and other health needs.
3. Waiver of cost for diabetes education in SETMA's American Diabetes Association accredited Diabetes Self Education and Medical Nutrition Therapy program.
4. Appointment to an experimental, vision-preservation program at no cost.
5. Assistance with applying for disability.

SETMA Foundation

Are gas cards, disability applications, paying for medications a part of a physician's responsibilities? Absolutely not; but, are they a part of Medical Home? Absolutely! This patient, who was depressed and glum in the hospital, such that no one wanted to go into the patient's room, left the office with help.

He returned six-weeks later. He had a smile and he had **hope**. It may be that the biggest result of Medical Home is hope. And, his diabetes was treated to goal for the first time in ten years. He has remained treated to goal for the past two years.

SETMA Foundation

Every healthcare provider doesn't have a foundation and even ours can't meet everyone's needs, but assisting patients in finding the resources to support their health is a part of medical home.

SETMA Foundation

And, when those resources cannot be found, Medical Home will be “done” by modifying the treatment plan so that what is prescribed can be obtained.

The ordering of tests, treatments, prescriptions which we know our patients cannot obtain is not healthcare, even if the plan of care is up to national standards.

Hospital Care Summary

- With this infrastructure
- With this care coordination
- With this continuity of care
- With these patient support functions

SETMA is ready to make a major effort to decrease preventable readmissions to the hospital.

Care Transitions & Hospital Readmissions

With this vision, SETMA expects to significantly affect hospital preventable re-admission rates over the next two years and to sustain those improvements.

Supported by care transitions, coordination of care, medication reconciliation (at multiple points of care) patient safety, quality of care and cost of care will be positively impacted.